DOCUMENT RESUME

ED 192 498 EC 130 160

AUTHOR	Kressley, Catherine Gill
TITLE	Special Assistance for the Early Education of the Handicapped: Project SAFE. Final Performance Report: School Year 1978-1979.
INSTITUTION	Anne Arundel County Public Schools, Annapolis, Md.
SPONS AGENCY	Office of Education (DHEW), Washington, D.C.
PUB DATE	79
GRANT	G007602143
NOTE	87p.
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Disabilities; Handicap Identification; Infants; Parent Counseling; *Parent Education; Preschool Education; *Program Descriptions; Program Evaluation; Therapy
IDENTIFIERS	*Special Assistance Early Education Handicapped

ABSTRACT

The final report documents the progress of Project SAFE (Special Assistance for Early Education of the Handicapped), designed to provide educational services to young children (0 to 5 years) with severe and profound, multiple, hearing, orthopedic, and health impairments. SAFE's activities in the following areas are documented: public awareness/community outreach; interagency collaboration; child identification; screening, diagnosis, and individualized education plan; educational programs and services, including therapy; parent education and counseling; data collection and evaluation; individual and program review and modification; and interdisciplinary training of personnel. Sample forms, flow charts, and project publicity descriptions are appended. (CL)

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USOE Grant No. G007602143

Special Assistance For The Early Education Of The Handicapped Project SAFE

FINAL
Performance Report
School Year 1978-1979

Anne Arundel County Public Schools
Dr. Edward J. Anderson - Superintendent

EC130160

SPECIAL ASSISTANCE FOR THE EARLY EDUCATION OF THE HANDICAPPED

PROJECT SAFE

FINAL

PERFORMANCE REPORT

School Year 1978-1979

ANNE ARUNDEL COUNTY PUBLIC SCHOOLS
Dr. Edward J. Anderson - Superintendent

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JUL 3 1980

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

PROGRAM PERFORMANCE REPORT (Discretionary Grants)

FORM APPROVED
OMB NO. 51-R1091

Further monies or other benefits may be, but will not necessarily be, withheld under this program unless this report is completed and filed as required by existing law and regulations *(45 CFR 121, GSA FMC 74-7).*

Part I

All grantees with awards from programs listed under "General Instructions" above respond.

1. Date of Report:	2. Grant Number:
July 30, 1979	G007602143
3. Period of Report: From:	**To:**
July 1, 1978	June 30, 1979

4. Grantee Name and Descriptive Name of Project:

Project S.A.F.E. Special Assistance for Early Education of the Handicapped

Certification: I certify that to the best of my knowledge and belief this report *(consisting of this and subsequent pages and attachments)* is correct and complete in all respects, except as may be specifically noted herein.

Typed Name of Project Director(s) or Principal Investigator(s):	Signature of Project Director(s) or Principal Investigator(s):
Catherine Gill Kressley	

Part II *("Accomplishment" Reporting)*

A. All grantees, except for those with awards under 13.443 are to respond to this Section A. Grantees under 13.443 go to B of Part II.

All grantees with awards under 13.444 except those supported solely for "Outreach" activities are to follow the organization of categories listed below in presenting their performance reports. The categories are based on activities common to all Early Childhood projects with the exception noted above for projects solely supported for outreach activities.

(1) Direct and Supplementary Services for Children's Services
(2) Parent/Family Participation
(3) Assessment of Child's Progress
(4) Inservice Training for Project Staff
(5) Training for Personnel from other Programs or Agencies
(6) Demonstration and Dissemination Activities
(7) Coordination with other Agencies
(8) Continuation and Replication

The grant application for programs 13.445, 13.446, 13.450, and 13.520 provided for the following functions or activities as categorical headings in the budget and narrative sections:

Research and Development	Dissemination
Demonstration/Service	Preservice/Inservice
Evaluation	Training

Programs 13.451, and 13.452 do not usually require a breakout since the primary function or activity is intrinsic to the respective program.

For each of the above programs, functions, or activities *(as well as those of special import for certain programs; e.g., replication, advisory councils, parent involvement)* discuss the objectives and subobjectives presented in the approved application *(in narrative format)* in terms of:

(a) Accomplishments and milestones met.
(b) Slippages in attainment and reasons for the slippages.

Refer back to your application and utilize your quantitative quarterly projections, scheduled chronological order and target dates, and data collected and maintained as well as criteria and methodologies used to evaluate results for (a) and (b). For grantees under 13.444, in discussing training or personnel from other programs, include descriptions of types of training, institutions or organizations involved, and numbers of trainees and hours of training received.

Also highlight those phases of the plans of action presented in your application that proved most successful, as well as those that upon implementation did not appear fruitful. NOTE: Outreach grantees are to discuss accomplishments and slippages in terms of replication and stimulation of services, resources provided and field testing and dissemination and training in terms of types of personnel receiving training and the number of hours involved.

Grantees finishing this portion of Part II, go to C of Part II.

B. Reporting for Grantees under 13.443 *(Research and Demonstration).*

Discuss major activities carried out, major departures from the original plan, problems encountered, significant preliminary findings, results, and a description and evaluation of any final product. Either include copies of, or discuss: information materials released; reports in newspapers, maga-

zines, journals, etc.; papers prepared for professional meetings; textual and graphic materials; completed curriculum materials and instructional guides, or drafts if in a developmental stage, special methods, techniques and models developed; scales and other measuring devices used.

When finished with this portion of Part II, 13.443 grantees go to C of Part II.

C. All grantees are to respond to this section C. Discuss the following:

(1) Unanticipated or anticipated spinoff developments *(i.e., those which were not part of your originally approved subobjectives, but which are contemplated within the purpose of the Education for the Handicapped legislation, such as new cooperative inter-agency efforts, a decision by volunteer(s) to pursue a career in special education, new public school policy to integrate handicapped children into regular classrooms, enactment of mandatory or other State legislation affecting early education, relevant new course offerings at universities, etc.).*

(2) Where outputs are quantified in response to any portion of Part II, relate quantifications to cost data for computation of unit costs. Analyze and explain high-cost units.

(3) Indicate other matters which you would like OE to know about *(e.g., community response to the project, matters concerning the project's working relationship with OE, technical assistance of OE staff, or any other relevant subject.).*

Part III

All grantees with a Demonstration/Service function or activity, except for 13.444 grantees who are solely supported for "outreach" activities, are to complete Tables IA, IB, and IC. All grantees under 13.451, as well as those under other handicapped programs with a Preservice/Inservice Training activity are to complete Table II. All grantees under 13.444 except those who are supported solely for "outreach" activities, are to complete Tables IIIA and IIIB.

Table IA – Demonstration/Service Activities Date

Children

Enter actual performance data for this report period into the appropriate boxes. Use age as of the time of the original application, or the continuation application, whichever is later. On lines above line 11, count multihandicapped individuals only once, by primary handicapping condition, and indicate the number of multihandicapped in line 12. Data for lines 1 through 11 are for those directly served; i.e., services to those enrolled or receiving major services, and not those merely screened, referred or given minimal or occasional services.

Type of Handicap	Number of Handicapped Served by Age					
	Ages 0-2	Ages 3-5	Ages 6-9	Ages 10-12	Ages 13-18	Age 19 and Over
Severely Profoundly Mentally Retarded 1. Trainable Mentally Retarded	6 10					
2. Educable Mentally Retarded	2	2				
3. Specific Learning Disabilities		4				
4. Deaf-Blind						
5. Deaf/Hard of Hearing	2	3				
6. Visually Handicapped	1					
7. Seriously Emotionally Disturbed		1				
8. Speech Impaired	8	7				
9. Other Health Impaired	2	2				
10. Orthopedically Impaired	3	2				
11. Total						
12. Multihandicapped	18	11				

If the data in the above table differ by more than 10 percent from the data originally presented in your approved application, please explain the difference.

Table IB

Project Staff Providing Services to Recipients in Table IA

Type of Staff	Number	
	Full-time	Part-time *(As Full-time Equivalents)*
Professional Personnel *(excluding teachers)*	1 Psychologist	.5 Project Directors
Teachers and Speech Therapist	2 Teachers	.5 D.P. Teacher 1.0 Speech Therapist
Paraprofessional	1	

Table IC

If applicable: Services to Those Handicapped Not Included in Table IA

Service		Number of Handicapped
Screened	28	3
Diagnostic and Evaluative	84	69
Found to Need Special Help	69	69 (Includes Speech)
Other Resource Assistance	15 Monitoring Service	

Table II

Preservice/Inservice Training Data

Handicapped Area of Primary Concentration	Number of Persons Received Inservice Training	Number of Students Received Preservice Training by Degree Sought			
		AA	BA	MA	Post-MA
Multihandicapped	20				
Administration	3				
Early Childhood	40				
Trainable Mentally Retarded	40				
Educable Mentally Retarded	20				
Specific Learning Disabilities					
Deaf/Hard of Hearing	10				
...ally Handicapped	2				
Seriously Emotionally Disturbed					
Speech Impaired	14				
Orthopedically and Other Health Impaired	23				
TOTAL					

If data in Table II above differ by more than 10 percent from those in your approved application, explain.

FINANCIAL STATUS REPORT

(Follow instructions on the back)

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED	2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER	OMB Approved No. 80-R0180	PAGE OF PAGES
Department of Health, Education, Welfare			

3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code)	4. EMPLOYER IDENTIFICATION NUMBER	5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER	6. FINAL REPORT	7. BASIS
Anne Arundel County Public Schools 2644 Riva Road Annapolis, Maryland 21401	52-6000992 W	91-2094	☐ YES ☐ NO	☐ CASH ☐ ACCRUAL

8. PROJECT/GRANT PERIOD (See instructions)		9. PERIOD COVERED BY THIS REPORT	
FROM (Month, day, year)	TO (Month, day, year)	FROM (Month, day, year)	TO (Month, day, year)
7/1/76	6/30/79	7/1/78	6/20/79

10. PROGRAMS/FUNCTIONS/ACTIVITIES ▶	(a)	STATUS OF FUNDS (b)	(c)	(d)	(e)	(f)	TOTAL (g)
a. Net outlays previously reported	$ -0-	$	$	$	$	$	$ -0-
b. Total outlays this report period	104,587.97						104,587.97
c. *Less:* Program income credits	-0-						-0-
d. Net outlays this report period (*Line b minus line c*)	104,587.97						104,587.97
e. Net outlays to date (*Line a plus line d*)	104,587.97						104,587.97
f. *Less:* Non-Federal share of outlays	-0-						-0-
g. Total Federal share of outlays (*Line e minus line f*)	104,587.97						104,587.97
h. Total unliquidated obligations	1,176.92						1,176.92
i. *Less:* Non-Federal share of unliquidated obligations shown on line h	-0-						-0-
j. Federal share of unliquidated obligations	1,176.92						1,176.92
k. Total Federal share of outlays and unliquidated obligations	105,764.89						105,764.89
l. Total cumulative amount of Federal funds authorized	120,623.00						120,623.00
m. Unobligated balance of Federal funds	14,858.11						14,858.11

11. INDIRECT EXPENSE	a. TYPE OF RATE (*Place "X" in appropriate box*) ☐ PROVISIONAL ☐ PREDETERMINED ☐ FINAL ☐ FIXED			
	b. RATE	c. BASE	d. TOTAL AMOUNT	e. FEDERAL SHARE

12. REMARKS: *Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.*

13. CERTIFICATION

I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

TYPED OR PRINTED NAME AND TITLE
C. John Belser
Senior Accountant

DATE REPORT SUBMITTED
August 1, 197

TELEPHONE (*Area code, number and extension*)
301-224-1557

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STANDARD FORM 269 (7-76)
Prescribed by Office of Management and Budget
Cir. No. A-110

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1. BACKGROUND

Project S.A.F.E. (Special Assistance for Early Education of the Handicapped) was funded by the Bureau of Education for the Handicapped (BEHHCEEP) in September, 1976. The intent of the program was to provide educational services to young children, ages 0 to 5 years, and their parents. The primary handicapping conditions addressed include severe and profound, multiply involved, hearing, orthopedic and health impairments.

The program was based at the Central Elementary School in Anne Arundel County, Maryland. The school has a student population of 666 students, pre-kindergarten to grade 5. Students are grouped in clusters according to their development rather than assigned to grades, although the age ranges correspond generally to those of traditional grade categories. A continuum of services including resource teachers, speech therapists and psychologists insure each child's placement in his/her least restrictive setting while pursuing their respective individual educational programs. The child's class placement and program design is determined by a school-based Admission, Review and Dismissal (ARD) committee. Thus, a child may be grouped with his/her peers for a part or all of a day.

The physical plant is an open space arrangement with large rooms known as pods. These pods are located around a central area that serves as a media center. The movement of the sixth grade class level upon completion of the local middle school in September, 1977, opened a large pod for use by Project S.A.F.E. and the Central Early Intervention Preschool Program. Renovations to the area included the installation of room dividers, appropriate early childhood classroom furniture, the addition of a kitchen area, and one enclosed classroom with deep sound absorbent closets. The enclosed classroom is used primarily by the preschool aged hearing impaired and language delayed children.

The majority of the children attending Central Elementary School are not in need of Special Education Services. However, an innovative mainstreaming program for orthopedically handicapped students is implemented here. Orthopedically handicapped students from the Annapolis and Southern Anne Arundel County area are bussed to Central School and integrated into the academic mainstream. A dynamic professional and paraprofessional resource staff supplements these students' academic program with individualized programs in rehabilitative areas, i.e., motor development, water therapy, fine motor, adapted physical education and self-help skills. Children who are functioning in the intellectually limited range and some children who exhibit behavioral disturbances are also educated at Central through the special education resource programs there.

The special student as an integral part of normal school environment has been enhanced by the strong administrative support lent by Mrs. Cathryn Johnson, school principal, who is, herself, orthopedically handicapped. Thus, the ideal of handicapped children learning, coping and growing in a normal environment has been a realized practice rather than an experimental concept.

Located next to Central Elementary is the Central Special Education Center. The facility is a self-contained unit for day students with moderately to severely involved and/or multiply handicapped students, ages 3-20. This physical plant, built in 1976, contains open-space classrooms, cafeteria, gymnasium, industrial and commericial shops, store, physical and occupational therapy areas (including a water therapy pool) and administrative offices. These therapy areas are used by the staff of Central Elementary, including Project S.A.F.E. personnel. Staff expertise, advice and training is also shared.

The setting for Project S.A.F.E. continues to be well appointed. The geographic area allows access to two major metropolitan centers: The Kennedy Institute in Baltimore and the Children's Hospital in Washington, D. C. The program, concentrating on children 0-5, is a natural extension to an existing successful special education structure. As a model, it is philosophically and programmatically linked with the intent of P.L. 94-142, regarding placement and progress of young handicapped children. It addresses the needs of unserved children (by age and by severity of condition) in both a home and school-based setting. It strives to provide timely intervention to families who are struggling with the problematic experience of parenting a handicapped child.

2. FY 1979 - PROJECT S.A.F.E. ACHIEVEMENTS AND CHALLENGES

By September, 1981, all handicapped children in the State of Maryland, 0-21, must be served. Program models are being developed and implemented to accommodate difference in handicapping conditions and geographic locations. The principal objective of Project S.A.F.E. is the development, implementation and evaluation of an interagency, regional demonstration model. This model can be replicated for the identification, diagnosis and education of all preschool handicapped or educationally at risk children under five years. (Appendix A) The project is parent-family oriented and leads to greater public awareness and community outreach, further parent counseling and education, and effective training of personnel.

The Project S.A.F.E. interagency, demonstration model includes all of the following areas of need for the early education of the handicapped:

- o Public awareness/community outreach
- o Interagency Collaboration

- o Child identification
- o Screening, diagnosis and individualized education plan
- o Educational programs and services, including therapy
- o Parent education and counseling
- o Data collection and evaluation
- o Individual and program review and modification
- o Interdisciplinary training of personnel

3. INTERDISCIPLINARY TRAINING OF PERSONNEL

The third year of Project S.A.F.E. afforded opportunity for the staff to continue its beneficial relationship with the Technical Assistance Development System. The specific services provided to S.A.F.E. included on-site consultation with needs assessor, small group seminar of record keeping, on-site consultation concerning alternate means of educational programming for severely-profoundly handicapped children and technical assistance in revising and editing dissemination materials.

The needs assessor was instrumental in helping the staff to clarify particular concerns which were surfacing in the second and third year of service delivery to handicapped children and families. The small project staff, consisting of a total of seven persons, had been struggling with communication concerns both within the staff and to the heterogeneous families that comprised the home and school-based population. These communication problems were exacerbated by the fact that some members of the staff were half-time employees and others had split roles and responsibilities. The needs assessor assisted the staff in devising new systems of intra-staff communication and in evaluating staff effectiveness in communicating with parents. Because the children ages 0-3 were served in their home by a single staff person, the need for optimal interdisciplinary consultation was critical. A product of this on-site consultation was the development of a new model for child staffing.

Periodically, a parent and child are invited to come into the school setting and participate in a 1 1/2 to 2 hour problem solving session with the total staff participating. The home teacher and parent prepared for this session by compiling a list of particular problems that they were encountering in the course of teaching the child. Modifications and revisions of goals and techniques were considered after the staff had an opportunity to review existing teaching techniques and demonstrated outcomes. Both parents and staff evaluated the problem solving sessions positively as being beneficial to parent, child and home demonstration staff person. A written summary of the session was distributed to the participants. (Appendix B)

The needs assessment process also set the framework for the above mentioned TADS services which were accomplished in school year 1978-79. In addition, the consultant aided the staff in identifying local resources to be tapped for services, advice or assistance. The staff considered the needs assessment service as being highly productive.

Subsequent inservice development activities included participation by a staff person in a small group seminar which addressed program record keeping responsibilities and techniques. Much of the information secured in this seminar was reviewed and evaluated for Project S.A.F.E.'s needs in the present and in the coming year.

Dr. Ed Zaromski presented a two-day workshop for staff persons and guests from local and area programs serving young severely-profoundly handicapped children. A total of 32 persons were in attendance, including parent participants. The format of the workshop included information sharing and demonstration with children from the S.A.F.E. population and from the Central Special Education School. Major topics addressed included development of appropriate educational goals and objectives, assessment techniques, parent involvement and training and the development of materials and equipment to implement active stimulation programs for severely-profoundly impaired children. The outcome of this workshop was the beginning of several active stimulation programs for SPH children, in the S.A.F.E. program and in two special education facilities.

Ms. Alice Powers assisted the project by providing editorial work pertinent to dissemination materials. Her technical expertise was useful in producing final editions of the materials.

The project staff also participated in other inservice activities which were sponsored by a variety of educational and service delivery agencies in the Washington Metropolitan Area. Staff participation included the following workshops, conferences, and seminars:

Howard County Association for Retarded Citizens
Parent Professional Infant Stimulation Conference, Mariottsville, MD.

Washington Metropolitan Infant Consortium, Landover, MD.

Speech & Language Development Workshop, University of Maryland

Two-Day Workshop on Cued Speech, Gallaudet College, Washington, D. C.

Developmental Evaluation Services for Children (Project DESC) Montgomery County, MD.

Montgomery County Easter Seal Treatment Center: Technical Assistance and Training Project

The At-Risk Infant, Georgetown University Diagnostic Center

Psychological Evaluation of Children Birth to 3, Children's Hospital - Anne Arundel County Psychologist's Inservice

4. CHILD IDENTIFICATION

Child Find activities continued to be pursued in collaboration with the Anne Arundel County Department of Special Education and the Maryland State Department of Education during FY '79. Project S.A.F.E. staff contributed to the implementation of a process of county-wide referral and assessment services.

During FY '79, the project S.A.F.E. Child Find component canvassed the following sources in order to identify unserved or inappropriately served children with special needs:

Number	Canvassed
97	Anne Arundel County pediatricians
10	Publicly funded Head Start and Child Development Day-Care Centers
31	Anne Arundel County Pupil Personnel Workers
8	Public Health Nurses
6	Private and cooperative nursery schools
5	Metropolitan medical centers, i.e., Johns Hopkins Clinic The Kennedy Institute The Children's Hospital of Washington, D. C. Georgetown University Hospital
6	Regional preschool programs for handicapped preschoolers
3	Privately operated day-care centers
7	Anne Arundel County Health Department Administrators

The results of this active Child Find campaign yielded 152 children, 0.5 years, who were identified as being in need of a developmental screening or an educational diagnostic evaluation. Of the children assessed, special education placements were considered appropriate for 69 children. Project S.A.F.E. provided direct educational intervention with parent training for 55 children and facilitated placement in a least restrictive special education environment for the remaining 14 children. In addition, some 15 children were placed on a recheck list for follow-up evaluation in 3-6 months. (Appendix C)

The etiologies of identified children served in Project S.A.F.E. include the following developmental disabilities:

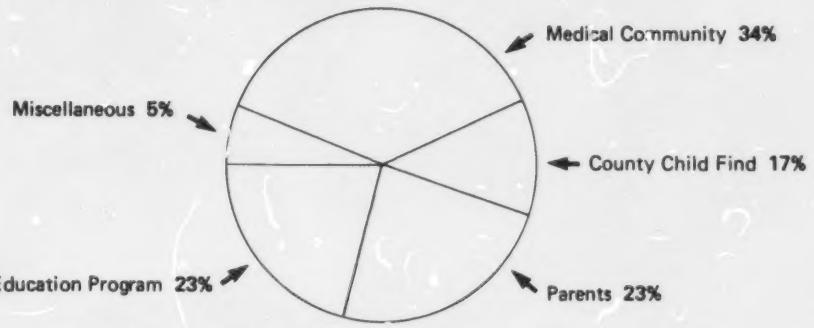
Project S.A.F.E. Population
Developmental Disabilities

Down's Syndrome
Cerebral Palsy
Spina Bifida
Seizure Disorders
Deafness/Hearing Impairments
Visual Impairment
Cleft Lip/Palate
Facial Tumors
Microcephaly
Hydrocephaly
Robert's Syndrome
Speech/Language Delays
Mental Retardation
Maple Sugar Urine Disease

Thirty-three of the 55 children served were handicapped by two or more discrete conditions.

During FY 1979, the fruits of increased public and community awareness were harvested as witnessed by the numbers of children identified prior to admission into kindergarten. The graph included below speaks to the percentage of direct and agency-related referrals received by Project S.A.F.E.

PROJECT S.A.F.E. CHILD FIND REFERRAL SOURCES



5. SCREENING, DIAGNOSIS, AND DEVELOPMENT OF THE INDIVIDUALIZED EDUCATION PROGRAM

A systematic procedure has been devised to ensure that a child is properly evaluated and appropriately placed. The staff recognizes that some parents are overly concerned about minor problems and others are insufficiently concerned about major problems. It cannot be expected that parents will be dispassionate in the evaluation of their own child and the project staff, therefore, carefully balances parent reports and developmental observations.

A. Screening

Initial contacts with parents are made primarily by telephone. The Parent's key concerns and feelings about his/her child's development are recorded and a date and time for developmental screening or educational diagnostic assessment is set (Appendix D). Generally, the screening of an infant or toddler takes place in the child's home, with the parent(s) present, at a time convenient to the parent and suitable to the child's schedule. An older preschooler may be screened either in the child's home or at the S.A.F.E. preschool site, with the parent present.

On occasion, it is more convenient for the working parent to request a screening either in the home of the child's babysitter or at the child's nursery school or day-care center. On such occasions, a conference is arranged to inform the parents of the result of the screening.

For children ages 0 - 2 1/2, the Denver Developmental Screening Test, items from the Infant Learning Accomplishment Profile, and the Receptive Expressive Emergent Language Scale, have been used. For children 2 1/2 - 5, a screening instrument has been compiled from the Learning Accomplishment Profile and the Preschool Language Scale (Appendix E). In addition, important developmental history is secured from the parent through interview by staff persons (Appendix G). The time spent with parent and child in conducting the developmental screening ranges from 45 minutes to 90 minutes, depending on the child's age, cooperation and fatigue level and the nature of the parents' concern.

Results of the developmental screening fall into several categories. The first includes those children who have no difficulty with the age appropriate language, motor, and cognitive tasks presented and appear to be well within normal limits at this time. At times, the parents of children in this category may express concerns about the adequacy of their parenting ability, especially in the area of behavior management skills and knowledge of "normal" expectations for a preschool child. The project S.A.F.E. psychologist is available to help parents who are seeking to improve their childraising skills and become more effective parents. To date, the project psychologist has counseled approximately 30 families in this capacity.

The second category of children includes those who have slight difficulty with some of the age appropriate tasks in one or more developmental areas. Frequently, these children may catch up after several months and slight delays may prove to be within the normal range of expectations. However, this category of child warrants a periodic recheck at 3 to 6 month intervals, until parent and professional are assured that development is proceeding well.

The third category of children includes those who experience significant difficulty with age appropriate tasks in one or more developmental areas. These apparent difficulties may be critical indicators of developmental problems. Consequently, a developmental diagnostic assessment is conducted by an inter-disciplinary team (Appendix H).

B. Developmental Assessment

The core of the interdisciplinary assessment team consists of the diagnostic-prescriptive special educator and the speech pathologist. When appropriate, the assessment team may also include the project psychologist. Additionally, diagnostic information may be secured by Anne Arundel County physical or occupational therapists. Medical, audiological, or opthomological specialists may provide necessary input to the assessment team.

The diagnostic assessment process accommodates itself to the unique needs of the child and the parents. The child may be evaluated in his/her home, at the S.A.F.E. preschool site, at nursery school, or at the day-care or Head Start program. The child's parent or a familiar adult is present during the evaluation. Although an evaluation may be completed in one session, it is not unusual for a series of evaluatory sessions to be necessary.

The diagnostic assessment instruments used include both formal and informal devices. The instruments chosen and the approach used are dependent upon the age and estimated developmental level of the child as well as the professional's appraisal of the child's ability to interact with the examiner. Other factors such as attention span, presence of physical or sensory disabilities, fatigue level, and personality are taken into consideration in selecting appropriate instruments and planning and implementing the evaluation. Frequently, informal but well structured play-like situations yield most satisfactory results with the very young child.

The presence of the child's parent(s) or primary caretaker offers the child reasurrance in a new situation. From the parent, the examiner may gain vital information about the typicalness of a child's behavior and responses. In the home evaluation setting, familiar toys and activities may serve as icebreakers between child and examiner. Siblings may be drawn into the activities to encourage optimal performance.

Project S.A.F.E. recognizes that the parent of the child often brings his/her own anxieties to the evaluation session. Consequently, a discussion immediately following the session is held with the examiners, sharing their impressions of the child's performance. The examiner takes care to discuss the child's relative strengths as well as his/her apparent weaknesses. Parental concerns and opinions regarding appropriate educational needs are elicited.

After the available diagnostic data has been compiled, the examiners present their findings to the Central School Screening Committee. The school screening committee consists of the school principal, project psychologist, diagnostic-prescriptive special educators, speech pathologists, pupil personnel workers and others, i.e., social workers, public health nurse and physical therapist as appropriate. It is the responsibility of this committee to make specific recommendations concerning the appropriateness of special education placement and the type of special education services that will meet the individual needs of the child. This recommendation is forwarded to the Central Anne Arundel County Special Education Department who verify that all county, state and federal regulations have been met.

A formal parent conference is held after the screening meeting to discuss the recommendation for placement. After parent approval is secured, the child is enrolled in the appropriate preschool special education program. For young children with severe sensory disabilities, multiple handicaps and/or severe/profoundly handicapping conditions, and/or delayed development, the appropriate program is frequently Project S.A.F.E. Program Services.

C. Creation of the IEP

The IEP is the heart of educational intervention. It is the logical follow-up to the variety of assessment data that is compiled and it serves as the building block upon which all activities are planned. It is also the contract that is created between the parent and professional. The IEP operationally defines goals and makes concrete those frequently vague statements of eventual developmental attainments that pervade post-testing discussions with parents.

The IEP is tailor made to the individual child's strengths and weaknesses. Deficits that have been discovered through formal assessment become the basis for educational goals and objectives. It is, in essence, the guidebook through which the parent and professional will move as they create a strategy for the fostering of new skills. It serves as codification of ideas that will be carried out in specific sequence in accordance with the developmental process.

There ae several components to the creation of the IEP. First, parents are apprised of the meaning and significance of the child's particular areas of developmental delay. Data available from other sources such as work-ups from the Kennedy Institute or P.T./O.T. reports are incorporated into the discussion and the total evaluative portrait is sketched. It is vital that this discussion be an exchange of ideas as to the representativeness of the child's behavior so that the

examiner and parent can be assured that the observations are typical of the child's daily repertiore. The evaluator attempts to ensure that she/he does not conduct a lecture to the parent, but that it is a discussion featuring a mutual education process.

Secondly, the parent and professional discuss which skills will be encouraged and in which order these will be fostered. It is vital that both parties are in agreement in this area since this plan will constitute the weekly program that both will be expected to execute. Parental input is essential here since the parent is ultimately the person who must be satisfied with the plan of action and agree to implement it on a day-to-day basis.

The IEP is written with long- and short-term goals and approximate dates of expected skill mastery. Skills are broken down into component parts and written in behavioral terms so that achievement will be measurable.

Within the first few weeks of IEP implementation, the parent and professional continue to review whether the IEP is meeting the needs of the child. Sometimes the goals are too modest and at other times they are too far-reaching. In order to realistically serve the child, this period of potential refinement or alteration of objectives is an integral part of the IEP implementation process.

6. EDUCATIONAL PROGRAM AND SERVICES

A. The Home Demonstration Teaching Component

The home-based program is guided by the recognition of the parent as the primary teacher of his/her handicapped child. The parents of the young handicapped child may face challenges, anxieties, financial strains and discouragements which are unique to his/her child's problems. The emotional stages through which a parent of a young handicapped child passes have been well documented. The home demonstration teacher/therapist is frequently instrumental in facilitating family adjustment to and acceptance of their child's problems. Through regular home visits, a parent/professional partnership is formed which works to maximize the child's developmental growth.

Specific techniques are utilized by Project S.A.F.E.'s staff in order to meet the goal of parent/teacher teamwork. The diagnostic/prescriptive teacher generally accompanies the demonstration teacher to the home for the initial visit(s). During this visit, the objectives of the program are reiterated to the parent and assessment information is updated.

For subsequent visits, which are usually 1-2 hours in length, the home demonstration teacher/therapist plans a series of activities which she judges to be appropriate to the child's needs, based on the current assessment data. Materials, either teacher-made or commercial, are brought to the home or suitable materials available in the home are considered for use. Other factors to be considered in the planning of the visit include the presence of siblings, attention span and fatigue level of the child, and responsibilities and constraints of parents, i.e., work schedule, health. Activities are correlated to the Learning Accomplishment Profile and to supplmental curriculum materials. This plan serves as an individual program guide and evaluative measure of the child's progress during the school year. Parent participation in the formulation of his/her child's program is an important factor in ensuring parent commitment to the program. Additionally, such sessions allow parents to verbalize their expectations for their child's development and future and to seek information concerning present and future needs.

The nature of each weekly session is determined in part by the unique personality of parent and child; age, developmental level, sibling involvement and parent support needs. However, commonalities of structure have emerged. Initially, the teacher inquires about the parents' success or frustrations with the demonstrated activities which were outlined on the home assignment sheet during the previous visit. Other changes, problems, or victories noted during the week are also recounted. The teacher then proceeds with the planned activities modifying them as she works with the child. At increasingly frequent intervals, the teacher encourages the parent to engage in the activity and pays special care to encourage the parent in his/her interactions with the child. Factors such as eye contact with child, facilitation, positioning, praise and reward for approximate attempts, appropriate level of language input are considered as part of every activity.

The teacher remains cognizant of parent's need to experience success in teaching his/her child and endeavors to take a supportive rather than primary role as teacher.

Siblings, both preschool age and older, impact on the development of the handicapped child. Project S.A.F.E. recognizes the generally positive feelings of these siblings for their handicapped brother or sister and attempts to modify siblings' games and activities to make them more suitable for the handicapped member. Siblings as well as grandparents, babysitters, neighbors and friends of the family are frequently in attendance during the home visits. Whenever possible, participation and involvement of these concerned individuals is encouraged.

B. The Preschool Component

The Project S.A.F.E. preschool center-based component is located in the Central Elementary School. This non-categorical program serves children ages 3 through the 5th year and interfaces with Central's Early Childhood Intervention Program. Readiness for this group learning and socialization experience is determined on an individual basis, using county age guidelines.

Unique strengths of the S.A.F.E. preschool program include daily 2 1/4 hour sessions with door-to-door bus transportation provided. Early childhood special education, speech and language therapy, physical therapy and motor development are available through the inter-disciplinary team to meet the individual needs of the children. The project psychologist and diagnostic/prescriptive teacher serve as resources to the school-based component.

The children and parents involved in the S.A.F.E. preschool share similar program objectives as the home-based children and parents. The parent-professional partnership formulates an educational management plan (IEP) that is suited to the individual child's educational and therapy goals. Daily activities are correlated with the Learning Accomplishment Profile curriculum and individualized objectives within a structured nursery school format. Both the home-based and school-based child are reevaluated periodically, based on the on-going assessment data collected by teachers and therapists.

Parent-teacher communication is facilitated by frequent conferences, phone conversations, group meetings and the publication of a weekly newsletter which alerts parents to key activities of the preschool (Appendix I).

Many of the parents of children now participating in the preschool program received S.A.F.E. home-bound parent teaching training. Consequently, parent volunteer effectiveness as "teachers" of small groups or individual children is realized.

When appropriate, children may participate in a graduel mainstreaming experience interfaced with the elementary school kindergarten. Support help is provided through the S.A.F.E. and Central Preschool Special Education staff.

7. DATA COLLECTION AND REVIEW

Data collection during the third year is affected by several factors: pre-test data was frequently not undertaken until October 1978, post-test data was often gathered as early as April 1979; the severity of the winter weather forced frequent cancellations of school during late January and February. The reader is cautioned to interpret these results carefully, remembering that the time-span between pre- and post-testing was often six months and that service during almost one of these months was cancelled due to inclement weather.

It should be explained that assessment data collection was conducted when appropriate staff members were available for this task. Thus, language assessment could only be done by the speech therapists. Since each of the two half-time speech therapists had their own case load in addition to consulting for five to six other S.A.F.E. cases, assessments had to be arranged at the collective convenience of the teacher, assessor, parent -- and especially with the cooperation of the child. This is why assessments were not all conducted in September and June to reflect a traditional ten-month interval.

There is also the recurrent problem of evaluating the assessment instrument. Once again the Project S.A.F.E. staff utilized the Learning Accomplishment Profile as its observational tool. Even though scores for six areas of functioning are favored over a single developmental age-equivalent, it should be stressed that intra-category assessment is exceedingly difficult and only approximately accurate. Rarely does a child fit neatly into discrete skill categories. Skill scattering is usually present and for purposes of this analysis, developmental ages have been rounded off to reflect the child's general level of development in each area of functioning.

To analyze the attached data:

1) Children are grouped by handicapping conditions;

2) Children's first and last initials are used and their chronological age in months at the time of post-testing follows their name;

3) Age assessment in the fall of 1978 for each category appears in the "pre" column for the particular area of development. Age assessment in the spring of 1979 for each category appears in the "post" column. The difference between those two figures appears in the "Difference" column;

4) Explanations of unusual circumstances are footnoted and explained on the page on which the child's profile appears.

Discussion of progress will be broken down by handicapping condition.

A. Down's Syndrome

In analyzing the progress of the Down's group, it is difficult to yield meaningful generalizations. If one were to take an average of months of progress as measured by all six areas of the LAP, the mean of progress in all areas of functioning would be 3.48 months. This would certainly be a distressing conclusion, leading one to observe that intervention did not have an appreciable effect on an anticipated rate of progress of about 50%.

In examining the progress more thoughtfully, there are several factors that must be taken into account:

1) It is well known that Down's children frequently function close to that which is expected of normal children during infancy. There is, thus, an intrinsic difficulty in measuring "rate of progress" among children who, when identified, are functioning at a normal range for their chronological age. After ten months of intervention, it is quite likely that the child who is now sixteen months old will be functioning several months below his chronological age. If one were to use some sort of deviation or ratio IQ, the child would actually decline in his rate of progress. If one then wanted to use statistical comparisons in the baldest or most insidious way, one could actually conclude that rate of progress declines with intervention.

   Staff agreed that the most important goal in programming for each area of functioning was the continual qualitative mastery of skills and the fostering of the next sequential step in each individual's developmental path.

2) There are major intra-individual differences which belie the usage of a single developmental score to indicate functioning level.

   In reviewing the progress of the Down's Syndrome group, a division was made between children who were discovered at early infancy at the beginning of the 1978 school year and those who had been previously identified and were at least eight months old.

   In the former category, there were two children for whom service began at the ages of 2 weeks and three months. The two-week old was born in October and the family was referred to the program in the child's first week of life. The three-month old was born in June and even though contact was established within the first month, the program did not operate during the summer. Service for this child commenced in September.

   Both of these children have followed the optimistic pattern of Down's children in their first year. At the time of the spring assessment, they were both functioning at least 80% of their chronological age. The older child was evidencing particularly strong skills and in fact was performing in a superior manner to all the Down's Syndrome children known to the Project at this age.

   Within the second group, the majority of children had achieved at a rate exceeding 50% during the school year. This varied from an average of 2.6 months gain in social skills to 5.3 months gain in speech and language. There was significant variability both among skills and among children. In terms of skills, there was no single area in which children generally made steady progress. In gross motor, for example, one child made six months progress while another child made one month progress. Children who made exceptional gains in one area did not necessarily make similar gains in other areas. While there are really no "stars" in this group, there were several children who are currently functioning above the 70% traditional EMR cut-off in a number of developmental areas. There is but one child who is generally below the 50% mark. Gains tended to be erratic. The child who made the greatest breakthrough in any one area, i.e., a 13-month leap in speech and language skills, is at the age of 29 months, only at the 12-month level in gross motor skills.

B. The Severely and Profoundly Handicapped

The severely and profoundly involved child continues to present the greatest challenge in terms of yielding meaningful assessment data. The Learning Accomplishment Profile for Infants, the main instrument used for measuring progress, is insufficiently sensitive to the gains made by this group of children.

The programmatic weakness of not having an on-staff physical and occupational therapist was felt most keenly in this area. Four of the five children in this category were serviced by speech therapists. They were required to go beyond the distinction between speech and occupational therapy as they developed extensive feeding and visual/auditory stimulation techniques. Since all children in the area were simultaneously enrolled in the CRISP program, they did have the benefit of PT/OT input. However, this was not necessarily coordinated with the program offered by S.A.F.E.

Programming for SPH children was an identified area of need. In response to this need, TADS supplied Dr. Ed Zuromski for a two-day, on-site consultation to the program. Staff and guest professionals found this workshop on active stimulation devices and techniques to be extremely helpful and began to incorporate these mechanisms and principles into their teaching. Utilization of active stimulation techniques also lent itself to more sensitive charting of child progress. Minute progress could be easily measured through discrete analysis of skills. Thus head control could be broken down into a variety of subtasks that could be successfully charted. The quality of each aspect, for example, could be measured by counting the time that the child was able to engage in the particular sub-task. It is the intention of the staff to use a more easily demarcated method of assessment in the coming year, as the transition to a county program is completed.

C. Hearing Impaired

When examining the scores of the Hearing Impaired children, it is important to consider:

1) Children were placed in this category if their primary handicapping condition involved a hearing impairment which could include a fluctuating hearing loss documented by a history of chronic otitis media in the first years of life. This does not mean that this was the exclusive developmental problem. Some children also demonstrated deficiencies in fine and/or gross motor abilities. This becomes rather striking when it is observed in the pre- and post-test measurements that the language equivalent age of some children exceeds their gross and fine motor ages in spite of their language disabling condition.

2) Initial assessments frequently belie ability. Children with hearing impairments will often respond to strangers with caution and not display their true range of verbal skills. Even the most skilled examiner may need a number of separate contacts with the child to obtain an accurate idea of his abilities. The gains reflected by children in this category are the gains as exhibited in test performance. The fact that the evaluator in the spring had already spent most of the school year as the child's teacher obviously enabled the child to perform to the best of his/her ability.

3) Unlike the children in the other categories, those in the Hearing Impaired classification generally exceeded the age of three and received service in the five-day-a-week preschool. Of the nine children in this category, only two received home-based services. The other children were enrolled in the total communication/language development class at the Central Elementary Early Childhood Intervention Program. This class featured an intensive language program with classroom instruction provided by a speech pathologist/teacher of the hearing impaired and with supplemental assistance from additional speech clinicians.

4) For a minority of the children, language is measured in terms of signing ability. Since normal language acquisition and speech production are problematic for hearing impaired children, it is unrealistic to use conventional speech/language norms derived from a hearing population. It may be that a normal to a bright child has been successfully employing a gesture system that has been quite useful in pragmatic communications with his parents and siblings. The evaluator recognizes that the child is communicating, but there is confusion as to how this communication should or can be assessed. If only conventionally acceptable signs and words are considered scorable, then the child will probably score quite poorly. Intervention may consist of channeling these gestures into acceptable and universally recognized signs. The child who is communicatively motivated may then acquire an entirely new gesture system in a relatively brief period of time. His test scores may then reflect his ability to communicate in this new language and post-test data may appear as though he has made extravagant leaps of progress when he has actually transferred his communication system from a previously unscorable mode to one that can be now measured in terms of recognized manual signs.

In analyzing the results of the Hearing Impaired pre- and post-test scores, there are several trends to be noted:

1) Language skills are by far the greatest source of gain for children in this category. The mean chronological age for children in the school-based program (N = 6) in September was 46 months. These children had a mean language age at that time of 37 months. By June,

when they were retested (CA = 55 months) they had a mean language age equivalent of 51 months - a gain of 13 language months within nine school months. It should be noted that one child made only three months progress at that time. This situation may be partially explained by the fact that the child has two deaf brothers and a deaf mother. He has mastered an effective nonstandard communication system with his brother, who is also his classmate. This system can be considered analogous to the "twinning effect" documented in studies investigating nonstandard languages which developed spontaneously among some twins in the first years of life.

If his score is eliminated from the analysis, then the mean speech/language age is 37 months at the beginning of the year and 52 months at the end of the year. This yields an increase of 15 months in nine school months.

2) Fine and gross motor scores are a source of concern. Gross motor skills are pre-tested (CA = 46 months) at 41 months and post-tested (CA = 55 months) at 48 months. Fine motor was pre-tested at 40 months and post-tested at 45 months. It may be that so much emphasis was placed on language development and concept acquisition that other areas were relatively slighted. For children who were making major language breakthroughs for the first time and were experiencing success in their abilities to be understood, it seemed critical to maximize this exciting period. Pre-writing skills and tricycle riding seemed as if they could be held in abeyance for the present.

3) For the two home-based children, there were distinct achievements. The older child (CA = 38 months) progressed steadily in all developmental areas, generally functioning about five months behind normal age expectations. The younger child made age appropriate progress in all developmental areas and experienced significant growth in her signing abilities.

D. Deaf

There was only one child in this category. He continued to function age appropriately in all skills with the expected exception of language. Gross and fine motor skills and self-help abilities were within four months of age level at the end of the school year. Language was 15 months delayed, but represented a seven-month gain in a nine-month period. This child was enrolled in the class with hearing impaired children and was felt to benefit by his interactions with speaking children.

E. Speech/Language Impaired

Four children were primarily involved in the program because of speech and language handicaps. Three of these children had unusual problems that contributed to deficits in this area. One child had a cleft palate, another child had benign and recurring facial tumors requiring frequent oral surgery, and another had an undiagnosed biochemical disorder that affected numerous abilities besides speech. The fourth child was enrolled with speech considered her primary delay, although skills in other areas were also significantly depressed. This was later altered as it became obvious that this was secondary to retardation.

It is difficult to make general statements about the children comprising this category as their problems are so diverse. Each child did demonstrate progress, but it was progress that had to be uniquely measured. For the child with cleft palate, the measurement had to do with receptive language since surgical intervention prohibited emphasis on expressive language. For the child with tumors, expression actually exceeds her age, but there must be an emphasis on compensatory articulation techniques due to the radical surgery required to control this unfortunate condition. For the hyperactive child, heeding commands and direction following were integral to controlling unacceptable behavior. The retarded child had just begun to respond to "yes" and "no" commands.

F. Orthopedically Handicapped

There was only one child in this category whose main disability was orthopedic in nature. He was simultaneously enrolled in CRISP and profited from PT/OT intervention as well as home demonstration teaching. Major gains in gross motor skills were realized as well as steady progress in all areas except for fine motor.

DOWN'S SYNDROME

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
S.B.	30	21	27	6	15	21	6	16	21	5	12	16	4	15	18	3	19	21	3
S.B.	39	10	12	2	21	24	3	21	27	6	20	33	13	20	27	7	26	27	1
S.F.	18	8	12	4	8	15	7	9	15	6	8	12	4	8	13	5	8	13	5
M.H.	5		5			4						4			4			4	
E.M.	10	5	10	5	5	10	5		9		5	10	5	5	10	5	5	10	5
D.P.	36		10			15			18			10			15			18	
A.W.	22	8	9	1	7	17	10	9	9	0	8	15	7	6	12	6	8	20	12
K.C.	29	18	21	3	15	24	9	12	21	9	12	15	3						

[1]indicates that this child was made known to the Project S.A.F.E. staff upon birth, but was not assessed at that time.

[2]prolonged hospitalization prohibited an accurate initial assessment; post data is indicative of current functioning.

SEVERE/PROFOUND

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
G.H.	34	2	4	2	3	4	1	4	6	2	3	6	3						
M.S.	35	2	2	0	3	4	1	3	5	2	12	12	0	7	7	0	8	6	-2
K.W.	31		6			7			6			12			12			9	
S.Z.	33	3	5	2	2	4	2	5	6	1	3	5	2	3	1	-2	3	3	0
E.S.	26	0	2	2	0	2	2	2	4	2	1	3	2						

[1]No pre-test data is available on this child.

HEARING IMPAIRED

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
A.D.	38	24	30	6	21	30	9	24	33	11	27	33	6	24	33	11	21	33	12
K.H.	59	48	58	10	48	56	8				38	54	16						
V.N.	49										38	55	17						
J.O.	60	42	44	2	36	40	4				37	47	10	42	48	6			
R.O.	50										35	55	20						
K.R.	52	38	48	10	36	40	4	36	46	10	36	39	3	36	45	9			
M.S.	30		?7			30					18	18	0		34				
L.S.	15	12	12	0	12	15	3				4	21	17	11	21	10			
M.S.	59	36	36	0				45	45	0	38	50	12						

[1]This child was admitted to the program at mid-year

[2]This child was admitted to the program at 12 months; language is measured in signing ability.

DEAF

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
T.R.	52	38	48	10	48	56	8	45	60	15	30	37	7	35	48	13			

ORTHOPEDICALLY HANDICAPPED

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
T.C.	24	6	27	21	11	15	4	13	21	8	15	27	12	15	23	8			

SPEECH/LANGUAGE

(All levels are in months)

CHILD	CA	GROSS MOTOR			FINE MOTOR			SELF-HELP			LANGUAGE			COGNITIVE			SOCIAL		
		Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
A.B.	37	24	33	9	24	33	9	24	33	9	24	33	9	35			35		
T.R.	42	33	42	9	33	42	9	36	42	6	40	53	13						
A.Q.	37	24	30	6	30	36	6	27	33	6	22	26	4						
C.V.	36	21			18			15			14			18			21		

[2]This child was uncooperative during initial assessment and only speech and language could be tested.

8. PARENT PROGRAMMING 1978-1979

As Appendix J (dissemination, "Development of a Parent Program") indicates, Project S.A.F.E. staff concluded that an effective program model had evolved by the third year of funding. Attendance at parent meetings and responses to surveys underscored the success of this philosophy.

There were two parts to the parent program:

1) The nature of a home-based parent-infant program is such that there is constant informal "parent programming". Weekly home visits provide parents with both an opportunity to refine skills in working with their child as well as to have a time when they can discuss the total impact of rearing a handicapped child on the life of the family. The sensitive home-based teacher learns when it is important to incorporate events outside of the strict confines of the child's developmental growth into discussion. A parent frustrated by lack of child progress or one whose marriage is suffering from the burden of raising a handicapped child will often welcome the friendly concern of the home-based teacher.

   Project S.A.F.E. staff found that a delicate balance was frequently maintained between serving as teacher to the child and counselor to the parent. Many sessions were devoted completely to focusing on the child's development; some sessions were geared to events in the life of other family members. No matter how structure and model-oriented staff strove to be, it became clear that there were times when parental needs took precedence over child needs. Staff members found that extended family gatherings, holiday gatherings, child birthdays -- times when it became apparent to family members that the child was not performing in a manner typical of his peers -- could be particularly stressful.

   At these times, staff would employ professional judgment in choosing what course their visit should take. Lesson plans would sometimes be shortened or the time of the visit would be lengthened so that the parent would have an opportunity to talk with the teacher about events that impinged on working effectively with the child. Often, parental recognition that the teacher understood the difficulties they were experiencing was of great assistance to the family and enhanced rapport immeasurably.

   There were times when the problems of families became too complex for the teacher to handle. Even if she were qualified to deal with them in a counseling capacity, the time for discussion diverted her attention from working with the child. Frequently, the Project psychologist assumed the role of working with the family at this point.

   Since the psychologist often accompanied the teacher on home visits, he had established some degree of rapport with the family prior to referral. The teacher and psychologist would discuss whether it was appropriate for the latter to become more formally and independently involved in the family's problems and how this involvement should be accomplished. Generally, the psychologist asked one or both parents if it would be helpful for him to engage in counseling with them on a periodic basis. Counseling was usually undertaken in the family home.

   Counseling could be short-term, periodic or of moderate time and depth. When the needs of the family became more extensive than could be appropriately handled by the psychologist and when the focus of the counseling extended well beyond the program's purpose, outside referrals would be made.

   The availability of parent counseling enabled the teacher to focus more exclusively on the needs of the child. There were occasions when the teacher, psychologist and family concluded that it would be best to compartmentalize the concerns of the family and child into separate categories. The teacher would deal with the child's developmental program and the psychologist could deal with family relations.

   In essence, a three-part continuum was maintained for parent counseling:

   a) The primary person serving the family was the teacher.

   b) If referral became necessary, the staff psychologist assumed this function.

   c) If the needs of the family required more extensive involvement, outside referral would be made.

2) In a parent survey conducted during the summer of 1978, parents identified obtaining general information regarding their child's disability and obtaining medical/community resources as their greatest needs. The affective emphasis that had been previously featured was not considered as important as a desire to acquire more concrete information. They complained of contradictory reports from physicians, social workers and different program staffs. Parents felt particularly overwhelmed by the awesomeness of such institutions as the Kennedy Institute and felt unable to intelligently choose what diagnostic and intervention services they needed.

It was decided that a significant aspect of 1978-1979 programming for parents would concentrate on presenting a series of informational speakers' programs. Topics were suggested by staff and rank-ordered by parents. Appropriate speakers were then invited by the Project psychologist who served as coordinator of this program. The thrust of this series was expanded by including interested members of the community. The series was entitled "Project S.A.F.E. Parent-Community Meetings" and did, indeed, attract an increasing number of community participants (Appendix K).

The community nature of the meetings enabled Project S.A.F.E. to become better known in the county, assisted community members in understanding the program's purpose and gave parents an opportunity to meet personnel from other agencies. This latter part served to increase parental savviness about who to contact to inquire about services. It also prepared them to deal with the people with whom they would be required to interact once their child graduated from S.A.F.E.

Parental reaction to the meetings was generally quite positive. Attendance usually included approximately half of all families enrolled in the program and at least fifteen community participants. A January 1979 survey of parents concerning the value of these meetings yielded the following results:

(Percent of Parents - N = 20)

	Very Important	Important	Unimportant
Meeting other parents whose children have problems similar to my own child	90	10	0
Meeting other parents and hearing how they are coping with problems I have experienced	100	0	0
Meeting other parents and learning what they have done to help their child	90	10	0
Learning how the presence of a handicapped child can affect the whole family	80	20	0
Learning about community resources	100	0	0
Having a better understanding of how the medical profession deals with handicapped children	90	10	0
Gaining information that will be of specific help in working with my child	100	0	0

A summary of 1978-79 programs, included:

September 13 — Welcome, Staff Introductions and Parent Introductions

September 28 -- Panel discussion -- The Impact of Having a Special Child on the Family. I: Perspective of Siblings. Panel members included Mrs. Jane Niederberger, Principal of Barbara Augustine School for Severely and Profoundly Handicapped Children, and Ms. Corrinne Smith, senior at Duke University. Mr. Robert Meyers, feature writer for the Washington Post was unable to attend. Since the subject of siblings was of such prime interest, this panel was considered a good follow-up to our spring program.

Thirty people attended and again there was lively discussion with many questions posed by parents that could only be responded to by those who had first-hand knowledge of how family life is affected by a handicapped brother or sister. Topics included the centrality of the idea of having a handicapped child on all aspects of family life, exaggerated expectations that are placed on normal siblings because of the limitations of the handicapped child, the impact on professional interests, the shroud of seriousness that is usually cast over the family.

October 11 -- An Evening with Dr. Jerry McSpadden, Director of Anne Arundel County Special Education. This meeting enabled parents to raise questions that would affect their children throughout the coming year. It also gave Dr. McSpadden an opportunity to meet with S.A.F.E. parents, many of whom have little contact with the school system due to the home-bound nature of the program.

October 18 — Dr. Mary Coleman discussing new research with Down's Syndrome parents. Dr. Coleman, a noted national authority on Down's Syndrome, and advocate of the controversial B vitamin therapy approach to stimulation of Down's Syndrome children, spoke to 35 parents, staff, other parents and one pediatrician from the community. Since Down's Syndrome constitutes S.A.F.E.'s largest category of home-bound children, this was a program of wide appeal. Dr. Coleman's exhaustive knowledge of all aspects of this disorder was extremely helpful during the long question and answer session.

November 8 — Language Development Among Preschoolers: Treatment Strategies by Daniel Dinsmoor, Ph.D. Dr. Dinsmoor, psychologist in independent practice and at Baltimore's Regional Institute for Children and Adults, specializes in working with autistic and schizophrenic children, but has been involved with a variety of language impaired children. He had videotapes on specific strategies that he had used.

December 5 -- Genetic Counseling and Prenatal Testing by Richard Heller, M.D. Dr. Heller, founder of the amniocentesis clinic at Johns Hopkins, impacted much needed information to parents on a topic that is of critical importance to those who are contemplating having another child.

January 9 -- What to Expect from an Evaluation at the Kennedy Institute by Dennis Whitehouse, M.D. Dr. Whitehouse is Director of the Diagnostic and Evaluation Clinic at Kennedy. This topic was prompted by the many misconceptions and exaggerated hopes by parents regarding possible intervention from Kennedy Institute.

February 20 — Discussion lead by the new Occupational Therapist and Physical Therapist from the Anne Arundel County Health Department assigned to S.A.F.E. children.

March 7 -- The Impact of Having a Handicapped Child on the Family II: Perspective of Parents.

March 13 — Project S.A.F.E. staff discussion of the components of a multi-disciplinary evaluation.

April 3 -- How to Evaluate Special Education Programs: A Consumer's Guide. This program came at a time when new recommendations and placements are being made for the next academic year.

April 9 — Estate Planning and Financial Consideration by John Diuguid, senior partner in the Washington, D. C. law firm of Diuguid, Siegel and Kennelly, a father of a Down's Syndrome teenager.

May 1 -- New Rights for the Handicapped -- Recap of 94-142.

9. DISSEMINATION/DEMONSTRATION ACTIVITIES

Project S.A.F.E. continued to build public awareness of the ways and means of early intervention. During the third year of the Project, S.A.F.E. nurtured previously developed community relationships and embarked upon new dissemination strategies.

Demonstration and dissemination activities were accomplished in a variety of ways, utilizing media and printed materials and the broadened scope of staff experience. Printed materials were revised which presented child instruction and parent education components of the project. A slide/tape presentation developed in conjunction with county media specialists, encapsuled the wide scope of services provided by the Project S.A.F.E. model.

Considerable correspondence with school systems, universities, colleges and private agencies was generated by media outreach activities.

In keeping with the responsibility of demonstration, the project director, psychologist and other staff were both solicitious of and responsive to queries from interested individuals. Personal contacts with public and private agencies were tailored to the individualized needs of those parties. Workshops, presentations and conferences followed a flexible course, ranging from 1-2 hour sessions to full-day involvement.

Typically, the project presented a core of information specific to the following:

Start-up activities
Inservice training
Childfind and Assessment - Procedures and Suggested Materials, Instruments, Techniques
Development of Individualized Educational Program
Parent/Professional Partnership
Curriculum for Young Handicapped Children
Interagency Collaboration
Home Demonstration Teaching Techniques
Parent Counseling - Crisis Intervention

Information dissemination and exchange of ideas was accomplished on all of the preceding topics. Particular interest in infant teaching in the home and the education of the severely/profoundly handicapped youngsters was commonly expressed. Very young and very handicapped youngsters are just beginning to fall under the umbrella of public instruction as a result of federal and state enabling legislation. Clearly legislative mandates alone do not provide programmatic solutions to complicated educational issues.

Project S.A.F.E. workshops frequently provided a forum for problem solving sessions in response to the concerns of the participants. As part of the First Chance Network of Early Childhood Projects, the staff could refer individuals to other sources who were demonstrating a different solution to the issue of service delivery for handicapped infants and preschoolers and their families.

The staff was also afforded an opportunity to learn and grow through personal contacts with representatives of other areas. As by-product of our dissemination endeavors, the project's philosophical stance was refined and clarified. Internal program evaluation revealed a strong commitment to two key factors: interdisciplinary teamwork and parent participation and instruction in all aspects of their child's program. The timeliness of intervention at the very onset of a developmental disability has also been judged essential for parent support and child progress.

A. Dissemination Materials

Four major dissemination materials were produced to augment demonstration activities during the project's third and final year. A slide/tape presentation was developed for use in public information meetings, workshops, and conferences. This multi-media description centers on the 0-3 home-based component of Project S.A.F.E. A professional combination of slides, narration and music captures the major elements of the model. It gives the viewer basic information concerning the following.

1) Legislative history of early education of the handicapped

2) The need for prompt identification of children with developmental disabilities

3) Specialized assessment techniques

4) Developing an Individualized Educational Program

5) Parent-Infant activities with professional input and guidance

6) Parent counseling and education services

7) Community referral network

Project S.A.F.E. parents and children participated in the production of this material. The slide/ tape show was felt to be especially helpful in illustrating the workings of a home-based program, from the point of initial referral to the week-by-week parent-staff construction of developmentally sequenced activities for the handicapped child. The range of handicaps served by Project S.A.F.E. was also depicted through the slides of different children in many stages of cognitive and physical competence.

Evaluative comments concerning this material were positive. Viewers related that it was helpful to them in updating their ideas concerning the nature of education and educational materials. It also helped allay fears that the parents' life-style was infringed upon by the professional team. It provided concrete examples of the structure and scope of early intervention in the home.

A second material, entitled The Development of a Parent Program, (Appendix J), was produced to record both the project's particular mode of parent counseling and education and to help other programs develop and implement responsive parent programs in their areas. Specific guidelines concerning selection of appropriate format, content and techniques are offered. The strengths of the three major categories of parent activities, i.e., education/information, training and therapeutic models, are delineated. The timing and sequence of appropriate parent involvement components is addressed, as careful planning is critical to the total effectiveness of the parent program.

This publication also offers a history of Project S.A.F.E. parent involvement activities, including an analysis of the success of the program in the particular perspective of its population's needs.

A third dissemination material, entitled Project S.A.F.E.'s Greatest Hits: An Annotated Collection of Materials and Activities for Handicapped Children, (Appendix L), was also revised and distributed during the third year of the project. This publication was developed in response to a need for resource materials for parents and professionals in working with handicapped children birth to three years. The project staff considered the following factors as critical in developing educational-therapeutic activities for exceptional children:

1) that activities be both stimulating and fun for child and parent;

2) that materials be easy to make, assemble or secure; and

3) that games be versatile and able to meet individual learning needs.

Each activity incorporates a description of how the materials can be utilized and modifications which may be necessary for particular types of handicapping conditions. The collection provides suggested developmental ages and the suitability of the activity for specific types of handicaps. The collection was developed with suggestions by a multi-disciplinary team and parents.

A fourth dissemination material took the form of a progress report suitable for a targeted audience of educators, county and area legislators, and interested lay persons (Appendix M). This material served two functions. First, it provided an in-depth overview of the program's components, achievements and goals. Secondly, it described how the demonstration project functions as a part of the local education agency and the short- and long-term benefits of this association.

This material was judged to be highly effective in providing local policy makers with information on which to base decisions concerning continuation and expansion of this program in school year 1979-80.

The Project S.A.F.E. staff, as advised by the original program objectives, investigated the feasibility of producing a comprehensive curriculum for children 0 to 5 years. Preliminary to undertaking this task, the staff reviewed many of the available curricula. It became apparent that in recent years, a wealth of developmentally based curricula had been produced and distributed. Gross motor, sensori-perception, speech and language, cognition areas appeared to have been highly developed by projects and programs which were research based.

Consequently, the workscope of the project was revised as further contributions in this area did not appear to be in the best interest of staff utilization. The Maryland State Department of Education - Early Childhood Division, is completing preparations for field testing of a 0 to 5 year curriculum for handicapped infants and preschoolers. The Anne Arundel County System has been selected as one of three Maryland counties involved in the field testing of this curriculum. Participation in this effort by the continued birth to three program is expected in School Year 1979-80.

B. Demonstration/Dissemination Recipients

A listing of Project S.A.F.E.'s demonstration/dissemination recipients is given below. This list is not complete as dissemination/demonstration activities are continuing at the time of this writing. Additionally, correspondence and interaction with other programs is expected to continue as part of the expanded model to be implemented in school year 1979-80.

Workshops - Presentations

Anne Arundel County Association of Public Health Nurses
Maryland State Association for School Psychologists
Anne Arundel County Association for Learning Disabled Children
Harford County Committee to Investigate Services for Children 0-2 years
Montgomery County Principals Workshops
National Elementary School Principals Association
Anne Arundel General Hospital Medical Staff - Obstetrical - Neonatal Personnel
Prince George's County Preschool Centers
Anne Arundel County Association of Pupil Personnel Workers
Anne Arundel County Association of Speech Pathologists
Anne Arundel County Special Education/Early Childhood Teachers and Aides
Anne Arundel County Council Members
Anne Arundel County School Board
The Centers for the Handicapped Inc. of Montgomery County
The Prince George's County Early Identification Program
The Anne Arundel County Association of Retarded Citizens
The School-Community Coordinated Services Preschool Project - Euclid, Ohio.
Technical Assistance Development Services Small Group Seminar - Annapolis, Md.
Maryland State Superintendent of Education Meeting - Talbot County, Md.
Montgomery County Early Identification Program - Multi-handicapped

Dissemination Distribution

Universities and Colleges

University of Idaho - Division of Special Education
University of South Dakota - Center for the Developmentally Disabled
Purdue University - Department of Education
College of New Rochelle - Special Education Programs
Ohio State University - Department of Special Education
Ohio Dominican University - Early Childhood/Special Education Division
University of Michigan - Technical Assistance Project
The George Washington University - Rehabilitative Services

Private Agencies/Centers/Schools/Projects

Anne Arundel County Community Action Agency - Annapolis, Md.
Maryland State Developmental Disabilities Council - Baltimore, Md.
Infant Consortium of Metropolitan Washington - Washington, D.C.
Lexington School for the Deaf - Jackson Heights, N.Y.
Rehabilitation Programs - Poughkeepsie, N.Y.
Western Tidewater Community Retardation Service Board - Suffolk, Virginia
Dr. G. A. Barber Center - Erie, Pa.
Little Friends, Inc. - Naperville, Illinois

Serendipity Special School - Winfield Kansas
The Resident Home for the Mentally Handicapped - Cincinnati, Ohio
Mangere Hospital and Training School - Mangere, New Zealand
Project M.A.S.H. - Gallup, New Mexico
Elwyn Institutes - Elwyn, Pa.
St. Christopher's Hospital for Children - Philadelphia, Pa.
Seaside Education Associates - Gloucester, Maine
Developmental Evaluation Services for Children - Montgomery County, Md.

School Systems/Districts

Lamar Independent School District - Rosenberg, Texas
Special Education Department - Schwalmstadt, Germany
Edmond Special School Services - Edmond, Oklahoma
Washington County Board of Education - Hagerstown, Md.
Board of Education of the City of New York - Brooklyn, N.Y.
San Antonio Independent School District - San Antonio, Texas
Brighton Public Schools - Brighton, Colorado
Fairfax County Public Schools - Fairfax, Virginia

10. PROGRAM CONTINUATION AND EXPANSION

During Project S.A.F.E.'s third year, there was an increasing marshalling of support among parents of children enrolled in the program to seek continuation of services after the BEH grant had been

completed. A core of parents who had served on the Advisory Board were in frequent communication with the majority of families receiving S.A.F.E. services. This group of parents were adamant that services to this population continue and expand to serve all qualified children in the county.

The desire for continuation derived from several factors:

1) From analysis of parental responses to S.A.F.E. surveys, level of satisfaction at the service being rendered was high. Parents felt that their child's developmental progress was assisted by, if not due to, S.A.F.E. intervention. There was widespread fear that a decline in rate of child gains would occur following cessation of services. While parents generally recognized that S.A.F.E. did not magically create miraculous gains for their child, the most typical comments were that the home demonstration teacher could anticipate the next area of developmental concentration and assist in planning appropriate stimulation activities.

2) Parents never truly comprehended the implications of the fact that S.A.F.E. was a BEH demonstration program. Since direct service was the most visible aspect of the program in the community, it had simply been assumed that the exclusive purpose of S.A.F.E. was to provide service to young, handicapped children. There was reluctant and belated recognition that the program would not be automatically taken over by the county simply because parents supported it.

3) The Maryland By-law 13.01.04 ensured that service to handicapped children would begin by September 1980. There was a general expectation that county educational administrators would choose to adopt a program that was already staffed and providing on-going intervention in June 1979, as it would only have to soon begin preparing for compliance with the September 1980 service delivery date. Both staff and parents felt that the county would prefer to perpetuate a program that had been well received in the county rather than face the unnecessary burden of replanning for service to this same population fourteen months after S.A.F.E. had ended.

In addition to these factors, staff members had begun to view themselves as transdisciplinary interveners for children from birth through age three. The multi-disciplinary staff no longer operated from the single vantage of a distinct professional allegiance. Each staff member became familiar with the techniques and strategies of their colleagues' professional viewpoints.

Since the focus of concentration was on the 0 to 3 population, each staff member had to go beyond his/her training and explore a field which, itself, is only in its infancy. A professional comradeship, an appreciation that intervention in this area is a novel undertaking and a recognition of the uniqueness of the home-based family-centered model created a sort of "you can't go home again" mentally. Staff members became committed to serving young, handicapped children and equally committed to performing this service in the family's home. After participating in the creation of this program, staff members were reluctant to consider returning to more traditional roles.

Against this backdrop of parental and staff commitment to continuing this service, the fiscal reality of nationwide dissatisfaction with ever-burgeoning county budgets had to be confronted. The question of funding service to this population was posed at a time when many service-oriented programs were confronted with Proposition 13 style feelings among policy-makers and legislators.

This was compounded by the emergence of a vocal segment of the population that was taking issue with the provision of publicly funded programs for handicapped children below the age of five. S.A.F.E. could become a symbol of disenchantment with preferential treatment for the handicapped as well as cradle-to-grave social services.

The S.A.F.E. staff had never contemplated developing a long-range third year public relations campaign to battle for future public funding. Insufficient thinking was devoted to planning for the post-BEH phase since the requirements of service, completion of diagnostic evaluations and intra-staff consultation on IEPs and program implementation took so much time. To a staff caught up in frequent unanticipated events in the life of a client family, post-S.A.F.E. funding seemed a remote priority.

While a conventional public information campaign was not formulated, the S.A.F.E. staff conducted activities which made the program even more known to the community. Presentations before county organizations, correspondence with other professionals and hospital personnel, the ramifications of interacting

with families in a service and diagnostic capacity, an ever increasing role in discussion of service provisions with the Health Department and the community participation nature of the evening parent programs helped to make the purpose of S.A.F.E. familiar to a wider audience. Production of a film in conjunction with the school system's media center enabled the staff to broadcast its functions visually as well as in a verbal manner and assisted S.A.F.E. in becoming more visible.

Parents and staff maintained a belief that widespread recognition of the effectiveness of the program would ensure integration into the existing county special education structure.

In January 1979, the Director of Special Education announced that the Superintendent had chosen not to include service for the 0 to 3 population in the FY 1980 budget. Special education already consumed a large portion of the education budget and it was deemed unnecessary to fund a program a year before it was mandated to begin by state law.

The S.A.F.E. staff hoped that its February Advisory Board Meeting would provide information to policy-makers that would assist them in reviewing their decision. Unfortunately, the snows of February twice forced cancellation of scheduled meetings.

Parents of S.A.F.E. children mounted their own campaign -- telephoning and writing to Board of Education members, calling on county educational administrators and speaking before the Board of Education at its budget hearings. The Board of Education chose to include funding for this program in its FY 1980 budget, appropriating $219,000 for service to all handicapped county children in the birth through three category.

Parents again rallied in defense of the program when the County Executive included service to the 0 to 3 age group in his proposed budgetary cuts. Letters were sent and telephone calls were made to County Council members, an article appeared in the Annapolis Evening Capital (Appendix N) and a delegation of parents visited with the County Executive. At this meeting with parents, the County Executive announced that he had decided to support inclusion of the proposed Board of Education monies for this program in his budget.

Parents also spoke in support of funding during the public hearings component of the County Council meetings.

On the evening of May 31, the County Council included the $219,000 for the 0 to 3 age group in its FY 1980 budget.

11. PLANNING FOR THE 1979-1980 BIRTH THROUGH THREE MODEL

Despite the recurrent uncertainties regarding future program funding, the Director of Special Education convened a series of meetings during the Spring of 1979, designed to incorporate the array of input from county personnel that have worked with children in the birth through three range. Representatives from the Association for Retarded Citizens, the Community Resource Infant Stimulation Program, the Health Department, the Board of Education as well as parent representatives met on four occasions at the Board of Education.

Discussion centered around gleaning the strengths of the S.A.F.E. home-based program and the Community Resource Infant Stimulation Program (CRISP) center-based program and creating a single program. CRISP had been in existence for six years as a joint venture of the Association for Retarded Citizens and the Health Department. It had been created with the understanding that it would be dissolved when the Board of Education was able to take over administration and funding.

From parent surveys, it appeared that there were three generally positive aspects of a center-based program:

1) Opportunities exist for parents to meet informally and form friendships, share common concerns and strategies for problem solving.

2) Some children, particularly between the ages of 2 and 3, are able to begin interacting with peers as a prelude to in-school service.

3) Staff members can easily observe children and informally make suggestions to colleagues.

There were essentially three positive elements to a home-based program:

1) The child is served in his natural environment.

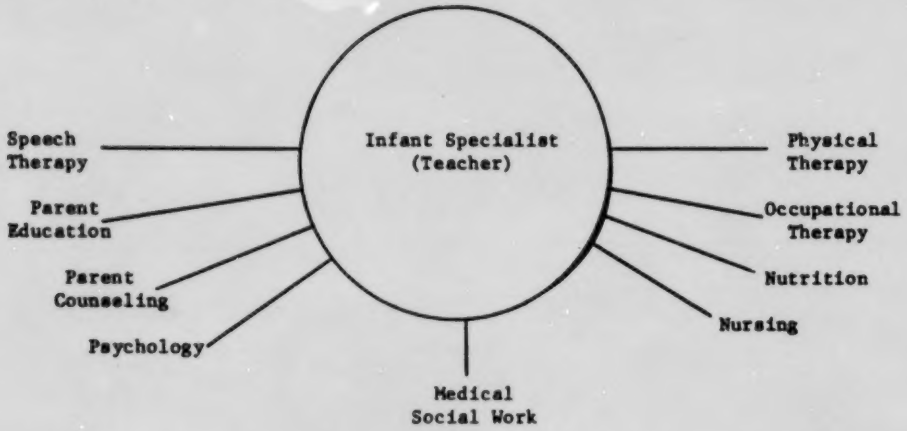
2) Transferability of skills by therapist to parent is maximized.

3) Teacher/therapist can, with adjunct personnel, identify and serve the needs of the entire family.

Since the Board of Education had recommended a home-based program, the major thrust of the proposal was to continue serving this population in the home. A monthly center-based option was considered valuable and strongly recommended.

This committee also proposed a model in which the teacher as the primary intervener, would serve as a Case Manager. This person would coordinate the supplementary services available, as needed, to each family. It was felt that this model would reduce the possibility of intervention by too many people attempting to be of service in a potentially overlapping and contradictory manner.

The primary intervener would be either the Infant Specialist or Speech Therapist serving in the Infant Specialist capacity. The available auxiliary personnel would include representatives from physical therapy, occupational therapy, psychology, nutrition, nursing, parent education, and parent counseling. Diagramatically the model would appear:



Each Infant Specialist would have time available with other team members. The other professional and the Infant Specialist would determine whether a home visit(s) would be necessary by the professional(s) or whether suggestions could be made by the supporting person to the Infant Specialist. It was hoped that videotape equipment would be available for use by home teachers so that concerns could be illustrated readily to the auxiliary specialist.

It was recognized that a sizable number of children enrolled in the program would require regular home-based physical and occupational therapy services. It was expected, however, that the Infant Specialist would be able to assist these therapists and provide support so that formal weekly therapy would not always be necessary to those who would benefit from this type of intervention.

Approximately 70 children and families are expected to be served by the birth to three Infant Stimulation program in school year 1979-80 (Appendix O).

Staffing requirements would include:

1 Coordinator/Diagnostic Prescriptive Teacher

1 Psychologist

6 Infant Specialists

- 2 Speech Therapists
- 1 Hearing Specialist
- 3 Early Childhood Special Education Teachers

2 Occupational Therapists

1 Physical Therapist

1 Consultant Nutritionist

1 Consultant Nurse

1 Clerical Aide

12. PROPOSED IMPLEMENTATION OF EDUCATIONAL/THERAPEUTIC IEP

Frequency of Service

It is proposed that each parent/child unit shall receive three home demonstration teaching visits per month by the Infant Specialist. Children in need of physical or occupational therapy shall receive home-visitation treatment and parent training as deemed appropriate by physician's orders and therapist's judgment. Health Department recommendations suggest that frequency of visits by therapy personnel be determined through flexible guidelines which take into consideration the individual needs of child and family.

Additionally, a once-per-month center visitation shall be made available to parent(s) and child.

Although it is anticipated that the majority of families can be served within normal working hours, some later afternoon and early evening hours should be made available to accommodate working mothers and fathers.

Programmatic Goals of Home Demonstration Teaching Component

The objectives of parent participation in home demonstration teaching sessions include the following:

1) Implementation of individualized goals and objectives, as stated on the IEP by providing the parent with specific skills to augment his/her skills as a teacher of the child.

2) Remediation or improvement in specific deficient areas.

3) Monitoring progress in non-deficit areas to ensure optimal developmental performance.

4) Incorporation of individual family strengths in teaching the child within the capabilities of the family, i.e., enhance sibling interaction.

Structure of Home Demonstration Teaching/Therapy Visits

In determining procedures to enhance accomplishment of IEP goals, the following components shall be present in the home demonstration visitation:

1) Parent/Professional Teamwork. The parent uses his/her special knowledge of the child in concert with the professional expertise of the teacher. The home visitor provides opportunities for the parent to practice and perfect specific skills necessary for their child's mastery of a particular developmental task.

2) Professional Accountability. The home visitor prepares appropriate activities and supplies toys/materials and equipment to supplement available home resources. Activities relating to IEP goals and objectives are modified to the child's learning style and parent's teaching talents.

   A written record (lesson plan) is prepared and parent and teacher collaborate in keeping weekly logs of progress made and problems encountered.

   Specific concerns which may be more appropriately addressed by a professional of a related discipline are recorded on a formal "Monitoring of Progress" chart and forwarded to the suitable team member. The monthly center-based session is structured to meet these identified needs through the involvement of the multidisciplinary staff.

Programmatic Goals of Optional Center-Based Component

The objective of parent-child participation in monthly optional center-based programs is multi-dimensional:

1) To provide a team approach to solving educational/therapeutic problems which have been identified by the home visitor and parent in the course of the preceding month's visits.

2) To provide opportunity for the full interdisciplinary team to conduct initial and on-going assessment of review of IEP goals, objectives and techniques of implementation.

3) To provide a structured, activity-oriented small group experience for exceptional children and their peers.

4) To provide parents with occasion to meet others who may have similar problems and concerns.

5) To provide parents with structured training and counseling sessions.

Scheduling Considerations

Composition of Team: The personnel involved in the professional team shall be composed of one physical or occupational therapist and one special education teacher or speech pathologist.

Numbers Involved: Each small group session shall include three to four children and their parent(s) and the two professional persons.

Length of sessions: 1 1/2 hours
Sessions per day: 3

Interdisciplinary Assessment/Development - Review of IEP

Composition of Team: The personnel involved in assessment shall be composed of one physical or occupational therapist, one speech therapist, one special educator. Other professionals, such as the psychologist, hearing or vision specialist, nurse, et. al., shall be included as appropriate.

Parent Component

It is expected that there will be several aspects to the parent component of this program in 1979-1980:

- parent counseling on an individual and group basis
- informational meetings and panel discussions
- informational and discussion meetings for siblings
- structured behavior management courses

Parent counseling will continue to be a major activity during 1979-1980. The psychologist will accompany the infant specialist on several visits during the early fall and introduce himself to new families enrolled in the program. It is important that families become aware that the counseling service is not an indication of a failure in parenting. Counseling conducted informally in the home helps de-mystify this service. It also enables the psychologist to assess whether more in-depth work is needed.

Informational meetings and panel discussions will be continued. A parent survey conducted during June 1979, demonstrated that this service is highly valued. Topics that have been favored for 1979-1980 include (in descending order of parental priority):

1) Financial Resources for Handicapped Children and Their Families - Representatives from Social Security, Internal Revenue Service, etc.

2) Estate Planning and Financial Considerations

3) The Subtle Problems Involved in Normalization of the Handicapped

4) Rights of the Handicapped

5) Panel of representatives from county organizations to discuss purposes and functions - Hearing Impaired Association, Spina Bifida Association, Association for Retarded Citizens, the Association for Children with Learning Disabilities, the Council for Exceptional Children.

6) Panel of parents with older, normal siblings discussing their older handicapped child

7) Genetic Counseling and Prenatal Testing

8) Panel of Professionals Beyond the School - A Consumer's Guide to Understanding the Players in the System - pediatric neurologist, psychiatrist, audiologist, child psychiatrist

9) Discussion of County Educational and Health Services

10) Panel of principals from County preschools to which children in the 0 to 3 would be eligible

Informational and discussion meetings will be conducted for siblings during 1979-1980. Techniques utilizing puppets, dolls and movies will give information on handicaps and reactions that other children have experienced.

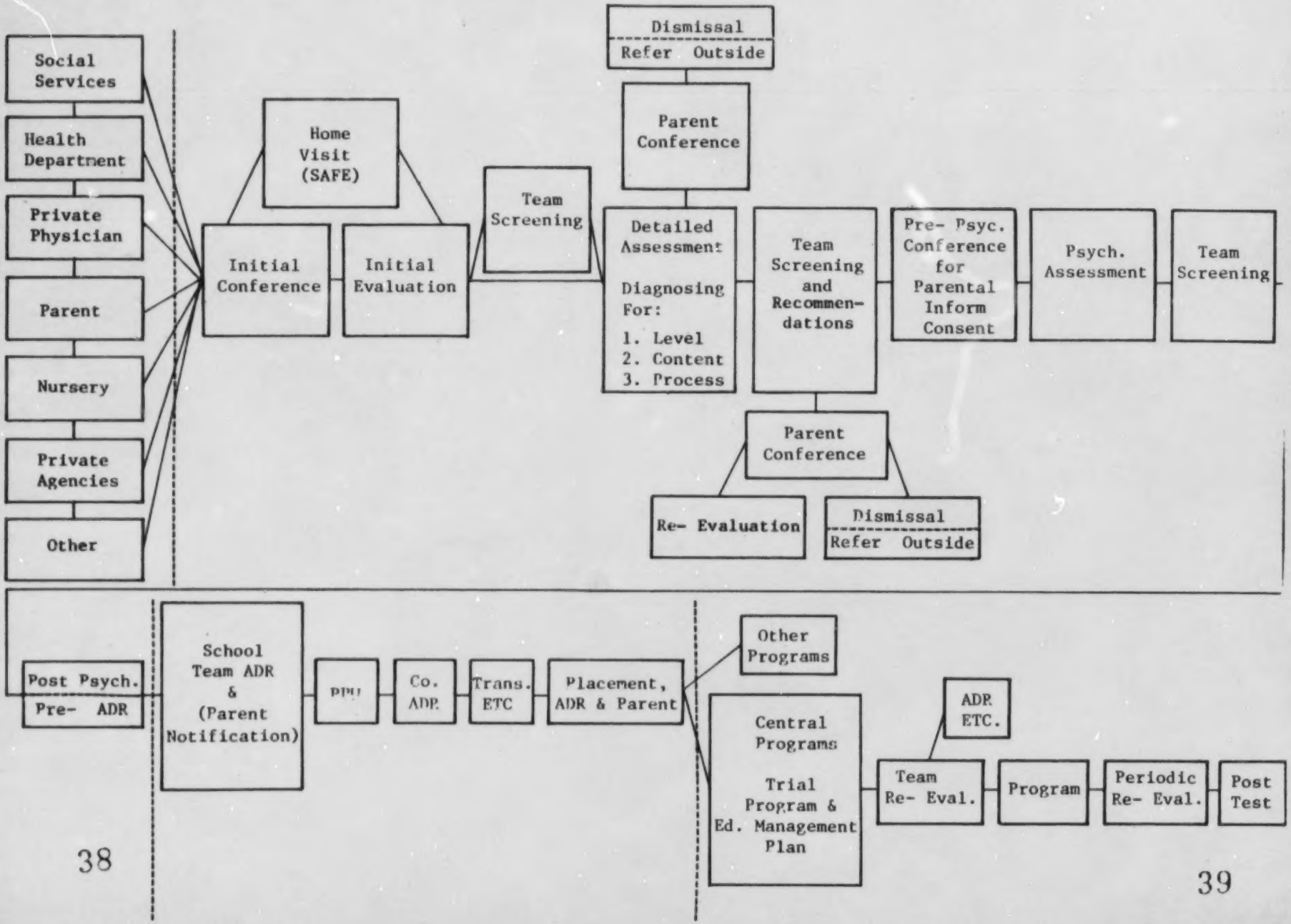
A structured behavior management course will be made available to parents. Utilizing a format such as the Portage Project, a program geared to the special needs of this population will be featured.

Appendix A

REFERRALS

PRE-SCHOOL PROGRAM

SCREENING AND ASSESSMENT



Appendix B
Team Focus Summary

PROJECT S.A.F.E TEAM FOCUS SUMMARY 1/30/79

Starring: Sammy B.

Co-Starring: Phyllis B. (mother)
Pam Emery (home demonstration teacher)

Supporting Cast: Catherine Kressley
Nancy Havlik
Carol Rothenberg
Ed Feinberg

FOCUS - on single or fewer activities. Let the child lead the way in exploring possibilities of play, at least part of the time.

RELAX - speech production demands. Look for understanding of language through gesture and behavior cues.

SLOW DOWN - language input. Give the child more time to digest what you say and what you do.

LINK - language, vocalizations and problem solving to movement.

CONSIDER - the child's need to concentrate when you reinforce him. A little pat or smile might be less disruptive to an activity that enthusiatic clapping or praise.

Sammy appears to be profiting from the daily play of his friend, who is close to his developmental age.

Appendix C
Diagnostic Summary Report

PROJECT S.A.F.E. DIAGNOSTIC SUMMARY - September 15, 1978 - May 1, 1979

	3 - 5 year olds	0 - 2 years olds
Number Referred	82	41
Evaluations Completed	51	26
Disposition		
Placement		
Level 1 Special Education	2	
Level 2 Speech	4	
Level 2 Parent-Infant		13
Level 3 Early Childhood Intervention	12	10 (Fall 1979)
Level 3 Hearing Impaired	5	
Level 5	2	2 (Fall 1979)
Summer Speech Recommended	5	
Hearing Resource Kindergarten	1	
Dismissed	20	2
Recheck List	11	3
Scheduled Assessments	15	
To be scheduled plus rechecks	12	7
Psychological	2	
Referred to other services	5	
Inactive due to health, residential treatment	3	2
No response to calls, letters	8	

Appendix D
Initial Contact Form

DATE:_____

CHILD'S NAME:_____

DATE OF BIRTH:_____

PARENT'S NAME:_____ _____
(Father) (Mother)

ADDRESS:_____

_____

PHONE NUMBER:_____

REASON FOR REFERRAL:

1) WHY:_____

_____

2) NUMBER OF CHILDREN IN FAMILY_____

3) HOW DOES THE CHILD UNDERSTAND INFORMATION?_____

_____

4) COMMUNICATION SKILLS (FAMILY/OTHERS)_____

_____

5) IN SCHOOL? HOW IS CHILD DOING?_____

_____

6) BEHAVIOR AROUND STRANGERS_____

_____

CONTACT PERSON:_____

DATE/TIME FOR EVALUATION:_____

DIRECTIONS TO HOME:_____

_____

Appendix E
Informal Screening Instruments

2½ to 3 years

I. Self Identification (Icebreaker - not scored)

1. Examiner presents three toys.

   Does child choose two? _____

   How does he/she play with it (fine motor coordination)? _____

   Spontaneous verbalization _____

2. What's your name? _____

3. Are you a girl or a boy? _____

4. How old are you? _____

II. Self-Help Skills

1. Tries to take off coat _____

2. Tries to put on coat _____

3. Feeds self without turning spoon upside down _____

III. Gross Motor (Items are to be presented first without visual demonstration, however, if the child is unable to perform a given task a visual model may then be given. If the child succeeds following such prompting, the item is scored correct.)

1. Walking — walks correctly _____ on tiptoes _____ abnormal walking pattern _____
2. Stairs — (doesn't need to alternate feet - can have helping hand) up _____ down _____
3. Running — on toes _____
4. Jumping — both feet (in place) _____
5. Ball — kicks it _____
6. Pushes — toy _____
7. Raises body from sitting to standing position _____
8. Stands on one leg momentarily _____

Comments and observations: _____

_____

_____

IV. Fine Motor

1. Crayon — holds with fingers _____
   scribbles _____
   imitates drawing of horizontal or vertical line _____
   within 30 degrees _____
2. Book — turns pages of book _____
3. Scissors — cuts functionally _____
4. Blocks — builds tower of 4" blocks _____ give me one block _____

5. Folds a piece of paper once after demonstration _____

Comments and observations _____

_____

V. Hearing Localization - Left _____ Right _____

1. Points to ball _____, doll _____, cup _____, and shoe _____. (Examiner stands behind child.)

2. Points to cat _____, bat _____, rat _____, and hat _____. (Examiner stands behind child.)

VI. Vision

1. Visual tracking - left _____, right _____.

2. Eye focus through tube - left _____, right _____.

VII. Language - Auditory Comprehension

1. Points to four body parts (4 is passing)

Hair _____, feet _____, hands _____, mouth _____, nose _____, eyes _____, ears _____.

2. Follows directional words (prepositions) (2 is passing)

Put the block on the chair _____

Put the block under the chair _____

Put the block in the cup _____

Put the block beside the cup _____

3. Understands usage (have child look at pictures) (2 is passing)

Show me what:

a. we use to comb our hair _____

b. we use to drink our milk _____

c. goes on our foot _____

d. we ride on _____

e. we use to iron clothes _____

f. we can cut with _____

4. Compares Size (Pictures) (2/3 is passing)

a. show me the tiny (little) spoon _____

b. show me the big car _____

c. show me the big dog _____

Comments and observations _____

_____

Language - Expressive (1 is passing)

1. Repeats two digits
Listen: say 2,
now say: 4-7 _____, 5-8 _____, 3-9 _____
(ignore faulty pronunciation)

2. Are you a girl? Yes _____ No _____

Are you a boy? Yes _____ No _____

3. Names objects in environment (4 is passing)

shoe _____, watch _____, table _____, ball _____, chair _____, block _____, pencil _____,

floor _____.

4. Sentence Repetition

Can you say, I am a big boy (girl)?

I like to play in the water _____.

I have a little dog _____.

The dog chases the cat _____.

Ignore faulty pronunciation. (Repeats one sentence)

5. Combines words in two and four word utterances _____

_____

Comments and observations _____

_____

VIII. Speech - Voice Qualities

hoarseness _____, nasality _____, loudness _____, softness _____, high pitch _____, low pitch _____,

too fast _____, too slow _____, other _____.

Articulation

Directions: The child's attention must be focused on the examiner. We are going to play a word game now. I'll say a word first, then you say the same word after me. Listen carefully. Say "baby."

All numbered items should be given to the child.

Scoring: Passes a group if all numbered items in that group are marked plus. Passes a numbered item if all underlined sounds in the (A) word or both (B) and (C) words are correctly pronounced. If (A) word is correct, do not give (B) and (C) words, which provide a second trial when necessary. If child misses (A), (B), and (C), stimulate child for sound in isolation.

_____ 1. (A) mom _____

(B) my _____

(C) home _____

"M" _____

_____ 2. (A) pop _____

(B) pie _____

(C) hop _____

"P" _____

_____ 3. (A) we _____

(B) won _____

"W" _____

_____ 4. (A) bob _____

(B) bee _____

(C) web _____

"B" _____

_____ 5. (A) nine _____

(B) new _____

(C) bone _____

"N" _____

Conversational Speech Intelligible Yes _____ No _____

Comments and observations _____

_____

4 to 5 years

I. Self Identification (Icebreaker - not scored)

1. Examiner presents three toys.

   Does child choose toy? _____

   How does he/she play with it (fine motor coordination)? _____

   Spontaneous verbalization _____

2. What's your name? _____

3. Are you a girl or a boy? _____

4. How old are you? _____

Comments and observations _____

_____

II. Self-Help Skills

1. Dresses self _____, puts on shoes _____, ties them _____, takes off shoes _____.

2. Button clothes _____

3. Feeds self _____, pour water from pitcher _____

4. Toilet trained _____

5. Separates from mother easily _____

Comments and observations _____

_____

III. Gross Motor (Items are to be presented first without visual demonstration, however, if the child is unable to perform a given task a visual model may then be given. If the child succeeds following such prompting, the item is scored correct.)

1. Walking — forward - eyes open _____, eyes closed _____

   backward - eyes open _____, eyes closed _____

   heel toe forward _____

   on tiptoes _____

   on a line _____

2. Stairs — upward _____, downward _____, alternating feet _____, without assistance _____

3. Running — runs well _____, on toes _____

4. Jumping — broad jump _____, 2 ft. _____, 3 ft. _____, over object (toy) _____, down from step _____

5. Ball — underhand _____, overhand _____, catches in arms _____, catches bounced ball _____, catches rolled ball _____, show hand preference (L or R - None)

6. Opens Doors — turns knob _____

7. Balance — stand on right foot _____, left _____ (4 to 8 seconds).

   need to hold hand _____, walk full length of balance board _____

8. Tricycle — peddles and steers _____, bicycle with guard rail _____ (ask mother)

9. Hopping right foot _____, left foot _____

10. Skipping _____ (doesn't need to alternate feet).

Comments and observations _____

_____

IV. Fine Motor

1. Crayon holds with fingers _____, scribbles _____

2. Copies Name _____

3. Copying circle _____, cross _____, vertical line _____, horizontal line _____

4. Tracing diamond _____

5. Scissors attempts to cut straight line _____

6. Blocks build tower (8-10 cubes) _____, counts 3 blocks _____

7. Draw a Person _____ (Have child identify body parts on picture. Examiner shall label these parts.)

Comments and observations _____

_____

V. Hearing

1. Points to ball _____, doll _____, cup _____, shoe _____ (examiner stands behind child)

2. Points to cat _____, bat _____, fat _____, hat _____ (examiner stands behind child)

Comments and observations _____

_____

VI. Vision

1. Visual tracking - left _____, right _____

2. Eye focus through tube - left _____, right _____, shuts opposite eye _____

Comments and observations _____

_____

VII. Language - Auditory Comprehension

1. Recognizes colors (4 colored blocks) (3 is passing)

Show me:

the red block _____

the blue block _____

the yellow block _____

the green block _____

2. Distinguishes prepositions (1 block) (4 is passing)

Put the block:

on the chair _____

under the chair _____

in front of the chair _____

beside the chair _____

in back of the chair _____

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3. Word order

Show me: (use objects)

the car hits the truck _____

the truck hits the car _____

the boy chases the dog _____

the dog chases the boy _____

4. Pronouns

Show me: (use objects)

he is walking _____

she is walking _____

they are walking _____

Put:

her in the cup _____

him in the cup _____

them in the cup _____

5. Understands (use pictures) (6 is passing)

Show me which one:

swims in the water _____

tells time _____

we write with _____

we read _____

we eat at _____

we put two pieces of wood together with _____

we cut with _____

6. Language - Expressive (2 is passing)

Repeats four digits

Listen, say 3-4-2 _____

Now say 4-9-3 _____

Now say 7-2-8-1 _____

Now say 2-1-6-4 _____

Now say 6-5-9-8 _____

7. Knows Opposites (2/3 is passing)

A. Brother is a boy, sister is a _____

B. In daytime it is light, at night it is _____

C. Father is a man, mother is a _____

D. The snail is slow, the rabbit is _____

E. The sun shines during the day, the moon at _____

8. Comprehends Physical Needs (3 is passing)

What do you do when you are:

sleepy _____

hungry _____

cold _____

9. Repeat Sentences (2 is passing)

Can you say I am a big boy (girl)? _____

A. May and I feed our little dog every day _____

B. My mother and father went to the store today _____

C. Our mother washes the dishes and sweeps the floor _____

10. Comprehends Remote Events (1 is passing)

What do you do:

when you have lost something _____?

before you cross the street _____?

11. Combines speech in 5 to 6 word utterances _____

Examples of spontaneous speech _____

Comments and observations _____

_____

VIII. Speech Voice Qualities

hoarseness _____, nasality _____, loudness _____, softness _____, high pitch _____, low pitch _____,

too fast _____, too slow _____, other _____.

Articulation

Directions: The child's attention must be focused on the examiner. We are going to play a word game now. I'll say a word first, then you say the same word after me. Listen carefully. Say "Baby."

All numbered items should be given to the child.

Scoring: Passes a group if all numbered items in that group are marked plus. Passes a numbered item if all underlined sounds in the (A) word or both (B) and (C) words are correctly pronounced. If (A) word is correct, do not give (B) and (C) words, which provide a second trial when necessary. If child misses (A), (B), and (C) stimulate child for sound in isolation.

_____ 1. (A) fife _____

(B) fun _____

(C) puff _____

"f" _____

_____ 2. (A) little _____

(B) like _____

(C) ball _____

"l" _____

_____ 3. (A) shush _____

(B) shoe _____

(C) push _____

"sh" _____

_____ 4. (A) six _____

(B) so _____

(C) house _____

"s" _____

_____ 5. (A) roar _____

(B) rabbit _____

(C) door _____

"r" _____

Conversational Speech Intelligible? Yes _____ No _____

Comments and observations: _____

_____

_____

_____

_____

Appendix F
Development History

PROJECT S.A.F.E.

Interviewer: _____ Name of Child: _____

Name of Informant: _____

IV. Developmental History

A. Birth History

1. How old was mother during pregnancy? _____

2. What was mother's condition during pregnancy? _____

3. Was the delivery normal? _____ Caecarian? _____ Prolonged? _____ Premature? _____

Instruments Used? _____ Birth Weight _____

4. Was there evidence of injury at birth? _____ What? _____

5. Were there evidences of weakness or poor health at birth? (i.e., color) _____

Explain _____

6. Was there any difficulty in initiating breathing? _____

B. Growth

1. During infancy, how long was child breast fed? _____ bottle fed? _____

Was child ever a feeding problem? _____ When? _____

How severe? _____

2. Age of teething? _____

3. Has child increased in height normally? _____ Present weight _____ Present Height _____

C. Motor Development

1. Please indicate age when the following skills were first performed:

Skill	Age
a. Creeping	
b. Crawling	
c. Sitting unassisted	
d. Walked with support	
e. Walked unaided	
f. Undressed self	
g. Dressed self	
h. Held cup	
i. Used spoon	
j. Toilet trained	

2. Does child seem to have normal coordination for its age? _____

If not, describe _____

D. Speech Development

1. Did he/she cry much during the first month(s)? _____ If so, was there a reason? _____

_____

2. Did he babble and coo during the first 10 months? _____

(make different sounds - put two sounds together?) _____

3. At what age did child use single words meaningfully? _____

4. Age for short sentences? _____

5. Does child understand what you say to him/her? _____ If not, describe his/her reactions

_____

Does child have trouble understanding other people? _____ Explain _____

_____

Are child's responses to sound in the home (doorbell, phone, voices) consistent? _____

Explain _____

6. Does child attempt to talk? _____ Is child's speech understood by parents? _____

borthers/sisters _____ strangers _____

What is child's behavior when he/she is not understood? _____

_____

_____

When you don't understand child's speech, what does he/she do to express himself/herself?

_____

_____

Give an example of a sentence child would say and how he/she would say it. _____

_____

_____

7. Does child hesitate and/or repeat sounds or words? _____ How often does this happen? _____

_____ When did you first notice this behavior? _____

8. Does child change his/her pitch (expression, high/low change, monotone, flat) when speaking?

_____

E. Social Development

1. Does your child sleep well? _____ Eat well? _____

2. Does child present any special behavior problems? _____ If so, what? _____

_____

F. Environmental History

A. Family

1. Names and ages of brothers and sisters: _____

_____

2. Others in household: _____

_____

3. Have any family members or relatives had the following difficulties?

Difficulty	Yes	No	Relationship to Child
Speech or Language Problem			
Learning Problem			
Learning Disability			
Reading Problem			
Emotional Problems			
Mental Retardation			

4. Are foreign languages spoken at home? _____

Appendix G
Parent Interview

Project S.A.F.E.
Central Elementary School
130 Stepney Lane
Edgewater, MD 21037

Parents Name _____ Home School _____

Please answer the following questions as best you can, and mail the form to the address given at the top of this page. If there are some questions which you cannot answer, leave them blank. Your answers will help us save time in understanding your child's problems.

I. Routine Information

Date _____

Name of child _____ Birthdate _____ Sex _____

Address _____ City and State _____

Phone _____

Name of person giving information _____ Phone _____

Relationship _____ Address _____

What is your major concern about your child _____

_____

_____

Please list the names of clinics or agencies where your child has been evaluated or treated

	Name	Address	Dates	Evaluated and/or treat.
1.				
2.				

II. Medical History

A. At what ages did any of the following occur?

	AGE	COMPLICATIONS
Whooping Cough		
Mumps		
Scarlet Fever		
Measles		
Chicken Pox		
Pneumonia		
Diptheria		
Croup		
Meningitis		
Sinus		
Earaches		
Chronic Colds		
Head Injuries		
Asthma		
Allergies		
Convulsions		
Encephalitis		
High Fevers		
Rheumatic Fever		
Enlarged Glands		
Hives		
Severe Headaches		
Fainting		
Running Ears		

B. Do any of the previous listed continue with your child (i.e., allergies)?

_____

C. Is your child being treated for any of the above conditions?

_____

D. Has a tonsil or adenoid operation been performed? Yes _____ No _____

By Dr. _____ at age _____ because of _____

_____ at that time.

E. List serious injuries, or accidents, age and effects:

Injury	Age	Severity and Effects

F. List operations and ages for each operation:

Operation	Age	Name of Surgeon, if known

G. Have the child's eyes been examined? Yes _____ No _____

H. Name of child pediatrician (or clinic) at present time

Name _____ Address _____

1. Is your child under medication at present time? Yes _____ No _____

   Reason _____

2. Does your child have any dietary restriction? Yes _____ No _____

   _____

III. Educational History (if applicable)

Has your child attended any school before? Yes _____ No _____

Name of school _____

How many times per week? _____ How many hours per day? _____

Dates attended _____

Does your child appear to get along with others in school? Yes _____ No _____

_____

Appendix H
Diagnostic Educational Assessment Reports

Central Elementary School
130 Stepney Lane
Edgewater, MD 21037

PROJECT S.A.F.E.
EDUCATIONAL ASSESSMENT

NAME: Allison Q D.O.B.: May 28, 1976
PARENTS: Mrs. Q
ADDRESS: Annapolis, MD 21401
PHONE:
DATE OF EVALUATION: December 1978 & January 1979
EXAMINERS: Catherine Kressley - Diagnostic/Prescriptive Teacher
Carol Rothenberg - Speech Pathologist

BACKGROUND INFORMATION

At the time of Allison's birth the Q's, a Navy family, were living in Iran. Allison had her first seizure there at six months of age. It was a Grand Mal seizure occurring for more than 24 hours and was accompanied by a 101 degree fever and loss of consciousness. No developmental setbacks were observed; anticonvulsant drugs were not presented at that time. One month later a 20 minute Grand Mal seizure was suffered. A "seizure disorder" was diagnosed and Allison was put on phenobarbital. Grand Mal seizures occurred one month later and then again five months later. The seizures were 10-12 minutes in duration. All seizures to this date were accompanied by low grade temperatures. At one point, within this time, Allison was sent with her mother to a hospital in Germany for an EEG. The mother reports that the doctors found it difficult to decide if it was normal or abnormal.

At one year of age Allison began to have eyeblinks lasting 1-3 seconds. At 18 months of age she returned to the Army Neurological Center in Germany. Another EEG revealed severely abnormal brain activity. The mother, a biochemist, remarks that EEG's are affected by stress and that Allison had two Grand Mal seizures in the hospital previous to the EEG. The pediatrician observed that Allison was developmentally normal at that time. Phenobarbital was continued.

The Q's returned to the states and Allison was seen at Bethesda Naval Hospital in Maryland. Allison continued to have short Grand Mal seizures every six months and 10-20 eyeblinks a day. In addition to phenobarbital, dilantin was added to Allison's daily seizure medications. Three bouts with pneumonia occurred, the last was very severe. Seizure medications were changed in an attempt to control the minor motor seizures (eye blinks).

Allison was transferred to Walter Reed this past summer ('78) and continues to the present under the care of Dr. Coker, a pediatric neurologist there. Medications have been changed and added. Allison was taken off phenobarbital since she is very active and the phenobarbital might stimulate this behavior. The drug ACTH, a cortizone derivative, worked well for Allison in controlling eyeblinks. (Grand Mal seizures have continued about every six months with two of the seizures lasting for an hour each.)

Unfortunately, ACTH cannot be given over long periods of time. At the present time, Allison is coming off of ACTH and is taking Tegretal, Sodium Valproate, and Mysoline. Dr. Coker has warned the Q's that Allison's type of seizure disorder is difficult to control and that the prognosis for normal intellectual functioning is "guarded."

Allison's parents have kept careful records of their daughter's seizure and other medical history and seem eager to help facilitate developmental progress.

It is important to note that Allison's behavior during this visit was extremely hyperactive (probably due to the fact that she was coming down off of ACTH.) It was very difficult to elicit her cooperation or attention in order to present toys, puzzles, pictures, etc. In addition, she was bloated in the face and abdomen (another effect of the ACTH). When Allison was visited a second time in her home she was off ACTH. Her weight appeared normal and her attention span improved drastically.

SUMMARY

Allison Q is a 30 month old girl with a seizure disorder. She is an active child who enjoys the physical challenge of a variety of geographical planes (steps, ladders, countertops, beds, etc.) and the mechanical challenge of the world of objects. Her motor skills are well developed and appear appropriate for her age. An independent child, Allison enjoys doing for herself so that most of her accomplishments in the self-help area are age appropriate.

Allison's language skills in the receptive area are also developmentally normal. Expressive language is delayed by approximately one year.

INSTRUMENTS USED

Learning Accomplishments Profile for Infants
Gross Motor LAP - developmentally normal
Fine Motor LAP - developmentally normal
Language LAP - Deficit Area

OBSERVATION OF PLAY BEHAVIORS

Because of Allison's high activity level and short attention span, no structured assessment was possible. Mrs. Q reported that Allison does not usually spend much time with toys and prefers other objects. She is particularly interested in her brother's tape deck which she manipulates in a trial and error fashion.

GROSS/FINE MOTOR SKILLS

Using LAP for infant developmental norms, Allison's skills appear roughly within normal limits, for gross motor, with some notable stiffness in running. She is presently about 12 pounds over her normal weight due to seizure medication.

Allison climbs steps easily and mounts furniture and tables. She can maneuver a small riding car with her feet but has not yet been exposed to a pedal toy.

Fine motor skills appear adequate in her manipulation of the environment. She is able to use forefinger to depress button, pulls ring to activate talking toy, turns door knobs, drinks from cup, turns key to activate toy. Mrs. Q reports that she uses a crayon momentarily. Based on these observations, it appears that motoric ability for age appropriate tasks is intact. However, short attention span and lack of interest in age appropriate toys may depress her overall fine motor functioning level. Her average observed sustained interest in a single activity was less than one minute; the exception to this was her fascination with the tape deck.

(Note: The observations described above occurred in December of 1978 when Allison was coming off the drug ACTH. Since that time she has been observed carefully. The present observations concur with the opinion above in that Allison's level of skill in gross and fine motor activities is appropriate for her age. Allison's level of activity is high but does not seem abnormal; her attention span seems within the range of normal for her age.)

LANGUAGE

Allison's receptive and expressive language appeared to be delayed by about 15 months (at 30 months of age) when seen in December during the initial visit. These observations appear directly affected by the fact that she was coming down from ACTH and her activity level was extremely high so that her attention was difficult (at best) to obtain.

Subsequently, Allison's receptive language skills appear quite appropriate for her age. She can point to objects and body parts and she responds to one step and some two step commands. She is not as yet interested in pictures and will not point to them.

Expressively, Allison's language is at about a 24 to 27 month level. She will ask for food or drink, she speaks in two word sentences using the pronoun "I" and asks the name of objects and activities ("Whasa?") Allison does not say her name (a 21 month skill), does not use pronouns other than "I" or use plurals (27 month skills) and does not name body parts or name objects by use (What do we drink out of, eat with?) Allison is not an imitative child and will not repeat words or sounds overheard or repeat words on command.

Allison's expressive vocabulary has increased quickly of late. She only recently, too, began putting words together. These two word combinations have quickly begun to predominate her speech. Mrs. Q informed the evaluator that her own nature is not particulary verbal and that she has recently begun to consciously talk more to Allison and to tune in on Allison's jabber to find words and phrases to which she (the mother) can respond.

SELF-HELP SKILLS

Self-help skills are judged age appropriate. Allison uses stairs, appropriately undresses herself and helps in dressing, and feeds herself using spoons, forks, and cup. She is very aware of when she wets or has a bowel movement and informs her mother (sometimes, although rarely, before when this happens). She is very interested in taking her clothes off and putting them on and likes to remove her paper diaper.

Central Elementary School
130 Stepney Lane
Edgewater, MD 21037

PROJECT S.A.F.E.
EDUCATIONAL ASSESSMENT

NAME: Leslie Ann S D.O.B.: March 1, 1978
PARENTS: Mrs. S AGE: 1 Year
ADDRESS: Annapolis, MD 21401
PHONE:
DATE OF EVALUATION: March 6, 1979
EXAMINERS: Johanna Greenhood - Speech Pathologist
Catherine Kressley - Diagnostic Prescriptive Teacher

Leslie Ann S is a cheerful one year old girl. She was referred to Project S.A.F.E. by Dianne Greyerbiehl, Consultant for Hearing Impaired Children in Anne Arundel County, following an audiological evaluation at Johns Hopkins Hospital. First results indicate that Leslie has a profound bilateral hearing loss that is possibly genetic.

SUMMARY

Leslie is a 12 month old girl with a profound bilateral hearing loss. She appears to be functioning, with scattered skills at about 4 months in language on the Language Accomplishment Profile. Non-verbal cognitive skills are about 9-12 months. Gross motor skills are near 10-12 months. Fine motor skills appear to be age appropriate.

BACKGROUND

According to Mrs. S, delivery was remarkable for difficult labor. Leslie's birth weight was given as seven pounds three ounces. She had an intolerance to a variety of formula, which probably caused repeated vomiting in the first six weeks of life.

Gross motor milestones were slow to emerge. Head control was unstable as late as eight months. Sitting unassisted was accomplished at eight months. Mrs. S said that Leslie's hips are double jointed which may be a factor in her late sitting.

AUDITORY

Through a phone conversation on February 28, 1979 with the audiologist at Johns Hopkins Hospital, Dr. James McDonald, it appears that Leslie has a profound hearing loss bilaterally. A Bicon body aid with a low frequency response has been placed on her and will be monitored to determine Leslie's reaction to amplification.

Mrs. S recounted that she notied Leslie was not responding to sound at three months of age. While she suspected Leslie was not hearing, several doctors advised her otherwise. About three months ago, Mrs. S had her daughter's hearing screened by Sue Murray at the Anne Arundel Health Department. Because of her lack of response, Leslie was referred to Johns Hopkins for Evoked Response Audiometry (tests brain's reaction to sound). At that time a diagnosis of profound hearing loss was made. Following one week of wearing hearing aids Mrs. S reports no change in response to external sound. There is a slight increase in vocalizations 'g, g, g' - 'k, k, k' - 'uhuh' and other sounds (laughter, chomping teeth).

OBSERVATIONS/PARENT REPORT

Leslie appears to be progressing more rapidly now motorically than in the past. Gross motor skills including side stepping, pulling to standing, crawling, hover about the 10-12 month level, according to LAP - norms.

Non-verbal cognitive areas also seem to be at a 9-12 month level. Leslie imitates adults in social play, waves bye-bye with visual cue, looks for hidden objects, and tries to imitate use of toy.

She mouths toys and objects quite frequently, which may be related to her profound hearing loss.

She is finger feeding independently.

At 10 months, Leslie progressed to a non-reciprocal crawl. She now side steps around furniture and pulls to standing.

Fine motor skills were reported to be achieved on schedule.

EDUCATION

Mrs. S has begun contact with The Maryland School For The Deaf, Columbia, in a home-bound program.

Appendix I
Preschool Newsletter

HAPPENINGS IN THE PRESCHOOL

Volume II | April 27, 1979 | Number 19

General Information

Today was the final day for summer school applications. If, for some reason, you did not receive one, call us and arrangements may be made.

On Tuesday, May 1st at 7:30 P.M. at Central Elementary School, Project S.A.F.E. will present Linda Jacobs, Assistant State Superintendent for Special Education. Her topic will be on "How to Evaluate Special Education Programs: A Consumers Guide for Parents." Do call in if you are going to attend.

The Ladies Auxiliary of the Shriner's have kindly made and donated to the preschool some tote bags that can be used by children to carry notes and goodies, etc. If you child needs one, let us know by sending a note.

Recipe of the Week

Carrot Salad: First, scrub the carrots well, but leave the skins on. Grate them into a big bowl. Mix in a couple of handfuls of raisins. Squeeze the juice from a lemon over the mixture. (Use only half lemon if you don't have many carrots.) Pour some honey or corn syrup over the salad until it tastes just right. That's it!

Miss Jo's Room

Last week the children had an enjoyable time riding a horse drawn covered wagon. Before we went, the children prepared for the ride through a short story. There, they took the roles of parents and children going on a wagon ride. Specific sentences were encouraged -- depending on the child -- as well as ideas of ownership (what belongs to someone), going fast and slow, as well as the vocabulary (covered wagon, reins) and the ability to take turns. Fine motor skills were worked on too, when we took large sheets of paper (newspaper is great at home) and drew by tracing dotted lines, coloring in large areas, drawing ourselves riding in the wagon. As we drew, we went over what we were drawing and what happened the day before (through the help of photography).

Later during the week we continued the idea of what other things we can ride in. This time it was a train. Through a short story, new vocabulary words - ticket, train station, train track, as well as ideas of fast/slow, going around (a mountain) and stopping or going on a red or green light were worked on. We concluded with the story book The Little Red Caboose. That gave some new words such as engine, first, caboose, tunnel and through as we read the pictures.

While we will really miss Trevor (he is moving to Idaho this week), his moving has provided a good week of language lessons and ideas. First we sorted out those things we can take with us (furniture, clothes, foods, dishes) and those we can't (steps, doors, walls). The next day, we became two families, one who was moving and their friends. After talking about why they were moving and how they felt, we called each other to say what was happening. We pulled out all that was in the drawers and cabinets in our house area and grouped them into different boxes. The next day we called the moving van, loaded the boxes onto the trucks and traveled to the new house (while they were moving a few of us stayed behind to rearrange the room). Upon arrival, they regrouped the clothing (pants, baby clothes, scarves and jewelry), food (eggs, fruit, cereal) and dishes (cups, plates, knives/forks/spoons). On the last day we received the week's lessons in two smaller groups, providing specific sentences for different children.

In addition to the lessons, we spent some time in circle on visual memory (remembering which object was taken away from a group); word matching (pairing a printed word with the picture and printed word); and auditory sequencing (placing objects in the same order that was told to them).

For fine motor/drawing skills some children worked on following dotted lines and coloring in that area then cutting it out after it was either blocked in or circled . Others worked on just coloring in an area, while still others worked on holding the crayons and making large movements.

Moving right along, we continued this week on our travels in moving to a new house. Part of the week, we re-acted the small group stories of moving that centered on certain types of sentences for each child as well as learning the items that are grouped under 'furniture' and 'appliance' (or machines). We did this by talking about what you do with each thing and noticed from that, that appliances do things for us (i.e., a refrigerator keeps things cold). When the moving van came, the children were asked to put in objects based on either a description (something that gives you light) or a category (furniture). In addition, Ricky, Kendall, John and Michael's group talked about the similarities and differences of moving from the country to city.

As a follow-up to these stories, short lessons were on putting together picture puzzles about moving. Large pictures were cut into three sections with a second whole sheet that contained an outline of the original picture. After the children matched each section to the whole picture, they were asked to tell something about the picture (what objects they saw, what the people were doing, where they were going, etc.). Following that, they sequenced these pictures according to those actions that came first, next and last when moving. On another day, we again became moving men. After being called by a lady on the phone the moving man came to select those pictures of things he wanted loaded into the truck. They were told either by the pictures being named, described by use (something you wear on your feet) or category (furniture, appliances, clothes). In addition, the moving man had to remember two or more things to pick up and then tell us what he got using the conjunction 'and' (a couch and a chair).

For fine motor art activity this week you will see the beautiful flowered cards made for Mother's Day. After coloring in the stems, the children painted the petals with glue and placed colored pieces of macaroni on them. FTD florists couldn't have done better.

For listening activities this week, the children, one day learned how to match the loudness and softness of their musical instruments as the loudness or softness of a record's music was changed. Through a song, they have been learning "I Know an Old Lady," the children have come to know some insects as well as animals. Also, which of these things were the smallest or largest and which came next in a song. (I know an old lady who swallowed a cat, she swallowed the cat to catch the bird, she swallowed the bird to catch the spider, ...)

The Three Kittens proved to be a good listening and remembering story this week. It was of three kittens who, started out as three different who started out as three different colors, but through a series of adventures became other colors. The children had to figure out what would happen to the kittens if the mouse started off gray and became white after running through some flour, and the kittens followed. Because of the simple, but active pictures, a lot of ideas about the actions were talked about, too, as well as vocabulary for colors; and concepts 'dirty,' 'clean,' 'wet,' 'dry.'

While at the end, the beginning of the day can't be forgotten. During circle we are working on finding out 'first' name. Next week we will go to our 'last' name since everyone has been doing very well.

Appendix J

DEVELOPMENT OF A PARENT PROGRAM

Parents of handicapped children need support, information and training to learn to deal with the special problems that their child presents. At no time is the need more acute that when the child is in infancy. Parent programming should be an integral part of any infant/early childhood project.

Parent programs generally fall into three categories:

- educational/informative models
- training models
- therapeutic models

The Educational/Informative Model

The educational/informative program offers a series of speakers or staff-conducted discussions to educate parents about community resources, the nature of the child's disability, intervention techniques and research. The underlying assumption is that parents need much information to become effective advocates for their child.

A good educational program can serve as a crash course in understanding a variety of subjects that parents will not be able to find in books or gain from doctors or friends. Parents learn about their rights, about professional resources and about current research. Ultimately, they can develop a sense of direction in planning for their child's needs as well as their own.

However, educational programs tend to be didactic. It is difficult to screen appropriate speakers and parents must often be sufficiently educated to understand the abstruse language of experts. Noncategorical programs that include a range of disabilities make it difficult to come up with topics of general appeal.

The Training Model

Training programs teach parents skills that can be used in home demonstration activities. They are usually behaviorally oriented and highly structured with mandatory weekly homework assignments. Instructors can range from a teacher with training in behavioral principles to a specially trained psychologist.

Early introduction to the behavioral approach provides parents with techniques for implementing home stimulation activities. Parents become more aware of how their day-to-day interactions with their child can promote positive and negative actions. Pre-planned, step-by-step programs are available.

Unfortunately, parents of very young children probably would not find much of the information directly relevant to their developmentally delayed children. Without a homogenous population, it is difficult to use examples that will be relevant to the entire group. There is also a danger that parents may confuse a developmental delay with an inability to correctly reinforce and shape certain behaviors.

A parent who attempts to uncritically employ behavioral techniques may develop a fairly rigid approach to child rearing.

The Therapeutic Model

Led by an experienced social worker or psychologist, the therapeutic programs have frequent (usually weekly) open-ended sessions in which parents exchange feelings about the effect of their handicapped child on their families. The group leader focuses on the common stages of grief that parents experience. Since parents often have fragile support systems, the group can be helpful in promoting a sense of commonality. Groups can assist parents in coming to terms with their own feelings while learning that these feelings are normal and have been felt by others. The assumption underlying the therapeutic program is that none of the carefully planned activities devised by infant teachers will be effectively implemented unless the parents are emotionally ready to help their child.

Because several parents in the group may be emotionally overwrought, the intensity of a therapeutic program may be inappropriate for all. Some parents can have a deleterious modeling effect on others who are managing reasonably well. It is important for the group leader to realize that many parental reactions are natural, transitory and may not be unique to those with a handicapped child. The leader must have a clear sense of time limits and move parents from open-ended ventilation to resolution and action.

Selecting a Parent Program

Faced with the three basic types of parent programs there are questions that should be asked before deciding on one model.

1. What is the purpose of the parent program?

2. Are there specific needs that a parent program is being designed to meet?

3. Have the results of previous parent programs been studied?

4. Is staff aware of the range of options for parent programs?

5. Have parents been included in discussion of the type of programs desired?

6. Has there been a survey of needs among the population that is to be served?

In determining which program or combination of programs is most suitable, certain factors need to be considered.

1. What are the socio-economic characteristics of the parent population?

2. Are parents located near a teaching hospital or university to which they may turn for additional assistance?

3. What additional community resources are available? Have most parents been made aware of these resources?

4. Are there other services, i.e., a community mental health agency, that are available for individual or group counseling?

5. What are the skills of the staff? Is someone available on staff or on a consultant basis who is qualified to lead a therapeutic group? Is someone on staff well grounded in behavioral principles?

During a child find program or prior to a child's admission to a program, an in-depth interview should be conducted by a social worker or psychologist. After compiling the interviews the staff should analyze the results. Are needs primarily in the affective or educational/informational domains? Are there particular topics in which parents have expressed interest? If so, the topics should be ranked in order of frequency of response. The staff should also consider general themes that are mentioned by parents, like disinterest by professionals, marital discord and the difficulty in locating community resources.

In analyzing this information it is important to account for the level of parental sophistication. A therapeutic group with an enormous educational range - from parents with less than a high school degree to parents with graduate degrees - could possibly be an uncomfortable mix. Staff must strive for topics that respond to parental interests, but that also reflect parental levels of understanding.

Lastly, interests should be matched with available and appropriate community resources. It does little good to discuss utilization of a research center unless parents have the opportunity for involvement.

Specific Planning for Specific Groups

1. Planning should be conducted as far in advance of the proposed dates as possible. If a program is to begin in September and run through June, it is optimum if planning can be executed in the spring or summer - 2 to 4 months before the first program is to begin.

2. The program series should have a logical flow with topics occurring at sensible times. For example, a topic such as "How to Evaluate Special Education Programs" should be held at a time when new placement recommendations are being made so that parents can visit schools and have some measurement criteria to evaluate proposed placements.

3. The entire series should be planned at the same time.

4. Decide how many programs are feasible. It is better to have fewer, well-attended programs than too many.

5. Decide what speakers or other manner of presentation (panel, media, program) would be best.

6. Determine the best time and day of the week for programs from parent interviews.

7. Compose a good letter as the basis for invitations to speakers. The letter should inform the reader about the project, give information on the expected number of people to attend, the general level of education achievement of the audience, the length of time that the person will have to speak, request for a resume' for publicity purposes, inquire if projectors or other equipment will be needed, and request that the person reply by a certain date. It is probably a better idea to invite a speaker for a general time than a specific date (i.e., the second week in October rather than October 10th) particularly if the speaker is likely to have many demands on his time.

8. Have a target date set for completion of program series. Make the date reasonable. It will probably take about three months for all answers to be received once the speakers have been selected.

9. Once all speakers and topics have been arranged, compose a brochure that could be mailed to parents and interested members of the community. The brochure should list the date, time, topic and speaker.

10. It is vital that babysitting and transportation be offered to parents. People trained as respite care sitters from the Association for Retarded Citizens will often come to the Center and babysit for all the children who accompany their parents.

11. Mail the brochure with an accompanying letter of explanation of your project to interested members of the community -- i.e., pediatricians, social workers, staff of the community mental health center, other schools, staff of hospitals, the local newspaper, members of the clergy, et al.

12. Send out program reminders about 10 days before the meeting with an RSVP request by phone for a day before the meeting.

13. Have a simple evaluation questionnaire ready for parents to fill out as soon as the meeting is completed.

Some considerations:

a. Parents must agree to attend every meeting.

b. Parents must agree to do short weekly homework assignments.

The advantage of this approach is that there are numerous prepackaged programs available for use. The Portage Project has published one that has workbooks for professionals and parents.

If interest is evidenced in this type of program, the course leader should select one of the available texts for use and decide how many sessions will be required to carry out the course.

A letter should then be sent to all parents announcing the availability of the program, the attendance requirements, and the fact that a certain minimum number of parents will be required to register if the course is to be held. An evening is preferable (with babysitting and transportation available) so that both parents could be more likely to attend.

1. A set number of weeks should be established for the group.

2. Attendance should be urged to be mandatory. It is disruptive to the group for people to attend one week and not the next.

3. Confidentiality must be stressed in the letter of invitation to parents.

4. Consideration should be given to the creation of separate fathers' and mothers' groups. If this is done, confidentiality should be guaranteed between one group and the other.

5. Depending on a program's child population, the leader may wish to consider having groups according to child disability -- i.e., all parents of Downs Syndrome children, et al.

6. The group leader should have referrals ready for those who need more intensive counseling than a session of this nature affords.

The S.A.F.E. Program

S.A.F.E. experienced the typical trial and error process in selecting a parent program. It went through three phases of parent programming: the first was dovetailed into existing preschool programs at the Central Early Childhood Intervention Program, the second was wholly therapeutic and the current program integrates the therapeutic with the educational format.

Since S.A.F.E. was housed at the Central Elementary School, it seemed logical to combine programs that were already being offered by the Early Childhood Intervention Program with the new S.A.F.E project. The Early Childhood Intervention Program had already been serving mildly developmentally delayed children from ages three to five for two years. Staff concerns and interests appeared to overlap. The other consideration that supported this decision was the existence of the Health Department-sponsored Infant Stimulation Program that offered weekly therapeutic parent groups. Some children were simultaneously enrolled in the S.A.F.E. and the infant programs.

The Early Childhood Intervention Program offered a series of evening meetings that were designed to supplement the activities of the preschool. Transferring skills from school to home were emphasized through presentations on language stimulation activities, fine and gross motor development, nutritional lectures, discussions of toy selection, reading readiness, sibling rivalry and mainstreaming. Parent attendance had generally been sporadic at these meetings. It was hoped that the inclusion of the S.A.F.E. parents would enhance the existing program.

It soon became obvious that home-bound parents had different needs from preschool parents. The magnitude of the handicap was a major obstacle to the creation of a homogenous evening program. It was, at best, unfair to subject parents of very young severely/profoundly handicapped children to detailed discussions of how to expand a child's language or how to encourage reading readiness skills. The S.A.F.E. and the Early Childhood Intervention Program were serving two very distinct populations and the staff recognized that a single parent component was not realistic.

The S.A.F.E. psychologist and staff decided that a therapeutic discussion group would be a good format for parent programming. The project had recently enrolled a number of children below the age of one year and it seemed that these parents could benefit from sharing common concerns. Also included in this group would be parents of preschoolers whose children's problems were more intense than those of the majority of other children.

A typical reaction among S.A.F.E. parents was the feeling of isolation and powerlessness upon the birth of their handicapped child. Even a year after the shock of discovery, parents were still sorting out their conflicting emotions. Parents had either rejected the idea that any problem existed at all or they were completely devasted, focusing all their energies on the new child and channeling priorities away from spouse, other children and former interests.

A series of five weekly discussion groups was held under the general title "I Gotta Be Me." Groups were held in the morning with transportation and babysitting available. An average of six mothers attended each session. Discussion revolved around the mother's despair, reaction of friends and family, marital discord, professional indifference and conflicting advice, and the time demands made by special feeding procedures and home therapy techniques. Despite the fact that each session was given a high rating consistent attendance was a major problem.

Our third and present phase of parent programming combines the therapeutic discussion model with informational/educational sessions. This model has been successful and was developed in response to parents' suggestions. The lecture program utilizes the considerable resources of the greater Baltimore-Washington area.

During the summer of 1978, the project psychologist conducted in-depth evaluative interviews with S.A.F.E parents. One phase of this interview was devoted to program recommendations for the coming year. The following year's program was based largely on parental suggestions. A brochure was distributed when the school year began. Program topics and dates were set so that parents would have an opportunity to plan attendance far in advance.

Approximately 50% of the families enrolled in S.A.F.E. have been represented at any single meeting. In some sessions speakers or panel members acted mainly as a springboard for group discussion.

The success of this program has been based on several factors: advance planning, inclusion of parents in the planning process, scheduling programs in the evening.

Appendix K
Project S.A.F.E. Fall Winter/Spring Parent Community Programs

PROJECT S.A.F.E. FALL/WINTER/SPRING 1979 PARENT-COMMUNITY PROGRAMS

All meetings are held at the Central Elementary School in Edgewater. Interested members of the community are cordially invited to attend. Please contact Mrs. Nancy Curtin at 956-5100, ext. 378, at least one day prior to the date of the meeting to inform her if you plan to attend. Coffee and conversation are featured from 7:00 to 7:30 PM.

1978 - 1979 SCHEDULE OF EVENTS

September 13	7:30 PM	Presentation of Project S.A.F.E. Program and Goals for 1978-79. Conducted by Project S.A.F.E. staff.
September 28	7:30 PM	The Impact of Having a Child with Special Needs on the Family: Perspective of Siblings. A panel discussion with Corrine Smith, Duke University senior; Mary Madeline, Anne Arundel County ARD Specialist; Robert Meyer, Washington Post feature writer and author of a forthcoming book on this topic.
October 11	7:30 PM	An Evening with Dr. Jerry McSpadden, Director of Special Education for the Anne Arundel County Schools. Open-ended question and answer session.
October 18	8:00 PM	New Research with Downs Syndrome Children. Mary Coleman, M.D., Director of the Childrens' Brain Research Clinic.
November 8	10:00 AM	Language Developmental Delays Among Preschool Children: Treatment Strategies. Daniel Dinsmore, Ph.D., Psychologist with the Regional Institute for Children and Adults.
December 5	7:30 PM	Genetic Counseling and Pre-Natal Testing. Richard Heller, M.D., Director of of the Genetic Counseling Center at Greater Baltimore Medical Center.
January 9	7:30 PM	A Discussion of the Facilities and Services Offered by Johns Hopkins and the John F. Kennedy Institute. Dennis Whitehouse, M.D., Director of the Diagnostic and Evaluation Center at the Kennedy Institute.
January 31	7:30 PM	Educational and Vocational Opportunities for Hearing Impaired Children. Panel discussion featuring: Mrs. Dianne Greyerbiehl, consultant for the hearing impaired in Anne Arundel County; Dr. Carl Jensema, Assistant Director of the Office of Demographic Studies at Gallaudet College; Ms. Colleen Klein, Vice Principal of the Maryland School for the Deaf in Columbia.
March 7	7:30 PM	The Impact of Having a Special Child on the Family II: Perspective Parents of Older Children. Panel discussion featuring Mr. and Mrs. Norman Hatfield and Mr. and Mrs. Michael Myles.
March 13	7:30 PM	The Components of a Multi-Disciplinary Evaluation at the Central Early Childhood Intervention Program. Presentations by teachers and therapists from the Central Elementary Preschool Program.
April 19	7:30 PM	Estate Planning and Financial Consideration for Parents of Handicapped Children. Presentation by John P. Diuguid, Washington attorney and senior partner in the law firm of Diuguid, Siegel and Kennelly. Mr. Diuguid is also the father of a Downs Syndrome young man.
May 1	7:30 PM	How to Evaluate Special Education Programs: A Consumers Guide for Parents. Presentation by Linda Jacobs, Ed.D., Assistant Superintendent for Special Education for the Maryland State Department of Education.

Appendix L
Project S.A.F.E.'s Greatest Hits: An annotated collection ...

Project S.A.F.E. (Special Assistance for Early Education of the Handicapped) is a demonstration-dissemination effort which serves young, handicapped children and families in Anne Arundel County, Maryland. Funding is provided by the Bureau for the Education of the Handicapped (Grant #G007602143).

Children enrolled in the parent-infant home demonstration program have a wide variety of handicapping conditions. Many are multiply handicapped and have severe deficits in developmental areas.

Project S.A.F.E.'s Greatest Hits Collection is comprised of materials, activities and games which have been found to be especially successful with handicapped children, infants through 3 years. The project staff considered the following factors as critical in developing educational-therapeutic activities for our exceptional children:

- that activities be both stimulating and fun for child and parent
- that materials be easy to make, assemble or secure
- that games be versatile and able to meet individual learning needs.

Each activity incorporates a description of how the materials can be utilized and modifications which may be necessary for particular types of handicapping conditions. The suggested developmental ages and the suitability of the activity for specific types of handicaps have been included as a flexible guide for use by parents and professionals.

The Project S.A.F.E. staff and parents hope that the results of their cooperative teamwork may benefit other exceptional children and their families.

Contributors: Project S.A.F.E. Parents
Project S.A.F.E. Staff
Catherine Kressley
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BOW WOW BO-NANZA

Description: Soft rubber or latex squeaky toys

Vendor: Available in pet stores

Activity: These colorful and safe toys are much easier to squeeze than squeaky toys purchased at a toy store. This greatly benefits children who have a very weak grasp. These toys will squeak if they are touched lightly or even if touched accidentally. They can be placed near a child who does not yet have a concept of cause and effect with the toy. As the child accidentally causes the toy to squeak, he might begin to connect his hand movement and the noise.

Developmental Age Range: 1-18 months

Special Needs Group: Infants, cerebral palsied, severely and profoundly handicapped, visually impaired, hearing impaired

RING MY CHIMES

Description: Plastic baby chimes musical toy which has three tumbles that chime.

Vendor: Fisher Price

Activity: These chimes make a musical sound if they are touched lightly. They can be activated by a swiping motion of the hand and arm. These motions can often be elicited in a severely involved (cerebral palsied) child by gentle, firm handling of the trunk and gradually working towards handling of the upper arm. As the body is handled in this way, the hand should be open in the spastic child. Then the child's arm can be moved in a swiping motion to make the chimes ring. Severely involved children seem to be delighted by this toy because they can learn to activate it by themselves.

Developmental Age Range: 2-18 months

Special Needs Group: Infants, cerebral palsied, severely and profoundly handicapped, visually impaired

BLUE BIRD REACH

Description: The Blue Bird is a music box which can be attached to the side of a crib.

Vendor: Fisher Price

Activity: This toy encourages reaching and gives experience in cause/effect sequences. If the child has difficulty pulling the ring, a larger plastic circle bracelet can be substituted to make grasping more successful.

Developmental Age Range: 2-18 months

Special Needs Group: Infants, cerebral palsied, severely and profoundly handicapped young children.

CAT IN THE BAG

Description: All that is needed is large crisp grocery bags.

Activity: To develop reciprocal kicking skill and for auditory stimulation, pull open paper bag up to waist level of infant who is lying on back or on side. Stimulate movement by helping infant make paper crinkle by moving legs. More advanced infants may enjoy crawling out of bag from chest level.

Developmental Age Range: 2 months and up

Special Needs Group: Not indicated for some cerebral palsied infants who become stiff and develop abnormal posture on their backs.

CRIB GYMNASTICS TOY

Description: Various safe infant toys suspended across a crib or playpen. Toys can be secured to sturdy string with baby elastic.

Activity: The advantages of the home-made variety of crib gym is that the items can be frequently changed as the child grows bored with them. Toys suspended by the baby elastic (purchased in sewing notions department) can be grasped and held for exploration and mouthing and bounce back when released. Some suggested items: measuring spoons, mouthable plastic flowers, toilet paper rolls covered with fabric, squeaky dog toys, beads. This toy can be strung parallel to a child who is placed in a side lying position to inhibit abnormal extension patterns. In this case, the toys should be low enough to encourage hands in a midline position. For visually impaired infants, toy should be strung very close to child initially so that any random movement of arms and hands will result in striking and activating toys. Distance may be gradually increased as infant begins to reach.

Developmental Age Range: 1-18 months

Special Needs Group: Infants, cerebral palsied, severely and profoundly handicapped, visually impaired.

HULA HOOP MOBILE

Description: A hula hoop can be suspended from the ceiling by three chains. Various sound and texture toys can be attached to the hoop at a comfortably playing distance for children lying on the floor.

Vendor: Toy stores

Activity: The toys attached to the hoop can be changed frequently. Several children can play with these toys at one time, thus facilitating parallel play. This type of position is contraindicated for children with spasticity if it elicits any abnormal, tense movement patterns.

Developmental Age Range: 2-18 months

Special Needs Group: Severely, profoundly handicapped infants, visually impaired infants, spina bifida infants.

TERRY CLOTH TUSSEL

Description: Large, soft terry cloth bath towel

Activity: A large towel can help to desensitize tactilely defensive children who resist handling and feeding. The child should be toweled with as few clothes as possible. Toweling should start on the back which is usually least sensitive. Move to the tummy and gradually toward the face. If the child seems to become tense, go back to a least sensitive area and repeat. The face and particularly the mouth is the most sensitive. Being handled or having the spoon or food touch the face can sometimes set off an extension pattern of the whole body with open mouth and tonic neck reflex. Total body toweling, along with inhibiting positioning, may help to detrigger the child's abnormal response to being touched. Some children with feeding problems are set off into abnormal patterns when they see their eating utensils. These utensils (spoon, cup, bowl, bib, feeding chair) can be introduced at non-feeding times as toys to desensitize the child to them.

Developmental Age Range: Infancy - upward as need dictates.

Special Needs Group: Tactilely defensive children.

SILKY SCARF SCREEN

Description: Medium sized light weight scarf of a neutral color.

Vendor: Dime Store

Activity: This size scarf seems to be most useful in beginning object permanence games. If a larger, heavier blanket is used, the child seems to focus on the blanket rather than on the object which has been hidden. He is more likely to be able to remove the scarf quickly before he forgets about the object.

Developmental Age: 5-18 months

Special Needs Group: Can be used by most children with special needs.

HAPPY APPLE

Description: Bright red, plastic, toy apple that makes noise.

Vendor: Playschool

Activity: Many parents report that this is their young child's favorite toy. Consequently, it is a good toy to hide in an object permanence game. The child can be moved or be encouraged to move to get this toy. As soon as he reaches it, his arms can be moved gently to make it ding.

Developmental Age Range: 6-18 months

Special Needs Group: Appropriate for all developmentally disabled infants.

WITH BELLS ON THEIR FINGERS ... (JINGLE BELL BRACELETS AND ANKLETS)

Description: Bracelets and anklets made from wide elastic and jingle bells sewn on.

Vendor: Homemade

Activity: Wearing of bracelets and anklets helps infant or severely involved child become aware of hands and feet. The pleasant jingle encourages eye-hand, eye-foot, mouth-hand coordination and sound localization. Bright red socks can also be used for short periods on hands to stimulate awareness of hands.

Developmental Age Range: 2-6 months

Special Needs Group: Infants with cerebral palsy, spina bifida, or severe or profound mental retardation. Also partially sighted children.

BEACH BALL RELAXACIZER OR RUBBER PLAYGROUND BALL

Description: Beach ball should be slightly under inflated so that child can grasp it more easily.

Vendor: Toy stores

Activity: With infants and severely involved children, the large beach ball can be used as a relaxation surface upon which the child is gently rocked while in a supine, prone or supported sitting position. The ball activities help to develop head control and righting trunk control and strengthening and side to side, front to back balance. With older and less handicapped children, the beach or playground ball can be used for learning to: push while crawling; carry when walking; kick while standing; chase up and down a hill; and throwing and catching.

Developmental Age Range: 1 month and up

Special Needs Group: Infants and severely handicapped children may benefit from relaxation activities with large beach ball. Other activities are appropriate for a variety of developmentally delayed toddlers and preschoolers.

FLASH LIGHTNING

Description: Any standard flashlight with colored cellophane (red, blue, yellow, green) to add variety to the tracking games.

Vendor: Hardware or Dime Store

Activity: The flashlight can be used for both visual tracking exercises and to promote eye-hand coordination. While the child is lying on his back or on his tummy and propping on his elbows, or sitting with support, get his/her attention by turning on the flashlight in a partially darkened room. When baby is looking at it, slowly move the flashlight to the side and watch for child to follow the light. When baby has accomplished "tracking" the light to one side, try to get her/him to track from one side, all the way across to the other. Try "tracking" vertically too -- from up above child's head to center -- to down below child's head. You can use colored cellophane over the light to make the game more interesting. You can also shine the light from behind child onto his/her hand while child holds a toy to encourage the eyes and hands to work together.

Developmental Age Range: 1-8 months

Special Needs Group: Visually impaired, severely and profoundly handicapped children, other developmentally delayed infants.

WALLPAPER BOOKS

Description: Large wallpaper sample books.

Vendor: Hardware and wallpaper stores will often give away their large sample books for free if you explain what you are using them for.

Activity: The pages in these books can be turned with the same large swiping motion as used with the baby chime toy but employ a large, more total arm movement. The wallpapers are bright, and of varied textures. Some children who can do few movements purposefully, can make this motion with some handling or support from parent or teacher.

Developmental Age Range: 6 months and up.

Special Needs Group: Severely profoundly handicapped, spastic, athetoid cerebral palsied.

POP - N - BEADS

Description: Pop-N-Beads are 1½ inch beads which pop together.

Vendor: Toy and variety stores.

Activity: These non-toxic, non-swallowable beads, have no sharp edges and can't hurt anything if thrown. Beads can be used to construct instant shaker toys using Pringles cans and other plastic or Tupperware containers. Beads can be combined with heavy cardboard egg cartons to make an eye-hand coordination activity. An egg box can be painted to match colors of beads for primary sorting and one to one correspondence activity. Beads can also be used for practice with pincer grasp. Paint the knob end of the bead with bright nailpolish. Adult may hold the main part of the bead until the child is able to grasp the painted knob with thumb and forefinger.

POP - N - BEADS (Continued)

Activity: (Continued)

The action of pulling beads apart and pushing them together encourages use of hands in a mid-line position. Adult can help spastic child achieve this by holding him securely in lap and gently rounding shoulders to prevent extension.

Developmental Age Range: 4 months and up, depending on activity

Special Needs Group: Can be appropriate for many young children.

FABRIC POTPOURRI

Description: Carpet square and yard goods scraps can be well utilized. Some suggested textures include fake fur, cloth, plastic or vinyl upholstery fabric, rough textured upholstery fabric, various length shag rug squares, rubberized fabric, velvet, crepe, jersey, door mat "grass," bubble packing plastic sheets, tulle (see through net).

Vendor: Can be donated by fabric and rug stores.

Activity: A multitextured playpen mat can be made for infants and severely or profoundly handicapped older children by sewing or gluing carpet squares onto a blanket. Multitextured mats, pillows and balls are also well used by young, visually impaired or blind children. Tulle or see through netting can be used to cover or wrap child in for exercise in spatial problem solving. Piece of fabric can be used for beginning match and sorting activities, utilizing texture, size, shape and color concepts. A texture notebook can also be constructed from a flexible plastic covered looseleaf notebook with rings large enough to allow easy turning of pages. Sample texture sheets are: 1) crackly sounding cellophane taped for non-rip edges leaving the cellophane somewhat larger than the backing sheet so that it is moveable by rubbing and sounds crackly, 2) Corrugated paper taped flat all around the manilla backing, 3) Cork sheet on backing, 4) Felt piece on backing, 5) Velvet glued and taped at edges, 6) Smooth plastic or oilcloth on backing, 7) Bubble packing plastic on backing.

Developmental Age Range: Infants on up.

Special Needs Group: Especially for infants, severely-profoundly handicapped preschoolers and visually impaired children.

STICKY BUSINESS

Description: Velcro is self-adhering fabric strips that can be used to modify toys and objects.

Vendor: Fabric Stores

Activity: Velcro can be attached to fabric toys and to a child's clothing to help the motorically involved child gain the experience of holding a doll or lovey close. It can be used in fabric stuffed blocks to help cerebral palsied children construct a tower (he will need help taking it apart). It can be used instead of difficult-to-manage buttons, zippers and other fasteners. Velcro in strips can also be used as a fine motor muscle builder. The child practices pulling pieces apart and hears the interesting ripping sound that it makes.

Developmental Age Range: Infant on up.

Special Needs Group: Motorically involved cerebral palsied children, infants.

GOING FISHING

Description: Materials consist of two or more long shoe laces and whatever appealing toy or object your child is interested in currently.

Vendor: Home-made

Activity: Tie the toy to a shoe lace and tie the other end to baby's high chair. Help your child see that he can get the toy by pulling on the string. If sitting balance is a problem, sit the child on your lap next to the kitchen table and place the string with toy on the table. After the child has mastered retrieving the toy by the string, next, place a string without a toy next to the string with the toy. Let your child select a string to pull and discover which one lands the toy. You can make this more difficult by crossing the strings so they form an X. Thick braided yarn attached to a toy may be easier for some children to grasp.

GOING FISHING (Continued)

Developmental Age Range: 10 months - 2 years

Special Needs Group: Developmentally delayed preschoolers

PEEK A BOO BLOCK OUT TOY

Description: This toy consists of a block suspended inside an open ended container, such as a round oatmeal box or a coffee can.

Vendor: Home-made

Activity: The block is suspended by tying a string around the block and then running the string through a hole punched in the container. Anchor the free end of the string with a large button or a clothespin. The string should be long enough so that the block comes out of the container when it is pulled. As the child plays, the block will disappear inside the container as the child pulls on the button and when the child pulls on the block the button will disappear behind the can.

Developmental Age Range: 6-18 months

Special Needs Group: Developmentally delayed

PERCULATOR PUZZLE

Description: The old fashioned (non-electric) perculator is one of the best of the "old reliables."

Vendor: Goodwill Stores

Activity: When child reaches the stage of enjoying taking out - putting in activities, the coffee pot will pose a good challenge for getting objects out for they cannot be removed by simple tipping or dumping. As an assembly toy you can help your child put the pieces together and he/she will enjoy taking them apart. Your child can practice pouring with it in the bath or sandbox.

Developmental Age Range: 12-30 months

Special Needs Group: Developmentally delayed.

PICTURE WINDOWS

Description: These "prebooks" consist of simple magazine pictures encased in clear plastic envelopes with rounded edges which can be purchased at a five and dime store or a stationary store.

Vendor: Home-made

Activity: Cut out pictures of words depicting child's receptive or expressive vocabulary and place them back to back inside the envelopes. Tape it shut and child can look at and handle the pictures without the distraction of turning pages and tearing.

Developmental Age Range: 12-24 months

Special Needs Group: Developmentally delayed.

DOWNHILL DERBY

Description: Construct an inclined plane with cardboard and large block. Use a wheeled toy such as a small car, truck and fire engine to knock down a roly poly clown or other obstacle.

Vendor: Home-made

Activity: This activity can be used for a pre-speech cognition activity and also to reinforce or develop language skills.

Developmental Age Range: 10 months and up

Special Needs Group: Developmentally delayed.

LEANING TOWER OF SOUP

Description: A collection of various sized full tin cans.

Activity: Tuna fish and single serving soup and vegetable cans (filled) make a good substitute for blocks in learning to stack and seriate. Using the tuna can as a base, the weight of the structure helps unsteady hands. When done on the kitchen floor, the resounding crash of the can helps to stimulate the child and help keep this fine motor activity going.

Developmental Age Range: 12 months and up

Special Needs Group: Developmentally delayed

TRASH CAN TOSS IN

Description: This game utilizes a large plastic garbage can (outdoor size) and rubber playground balls or large bean bags.

Activity: This favorite indoor or outdoor activity promotes throwing skills and eye-hand coordination. The teacher can individualize the activity within the group by holding the can very close for beginners (allowing success for entry level skills) and moving it away from more advanced students.

Developmental Age Range: 21 years and up

Special Needs Group: Developmentally delayed preschoolers.

FILLERUP

Description: A large cardboard box with plastic hose attached.

Activity: This inexpensive prop helps children to act out the familiar routine of buying gas for their trikes. This activity can reinforce sequencing and expressive language skills. A more complicated service station can be constructed from additional cartons — like refrigerator boxes and large blocks to make a lift for ailing cars and tricycles.

Developmental Age Range: 3 years and up

Special Needs Group: Speech and language delayed youngsters, developmentally delayed preschoolers.

FLAG TOY

Description: Any colorful scarf or men's necktie suitable for tying around a child's waist.

Activity: Many developmentally delayed youngsters have difficulty in learning abstract rules of simple games. Using the flag on the child who is "it" gives children a concrete symbol of who should be avoided and who has the turn to chase the others. The scarf is passed on to the next person who is tagged. In addition to gross motor development, learning standard preschool games helps slower youngsters make friends and fit in with neighborhood friends.

Developmental Age Range: 3 years and up

Special Needs Group: Developmentally delayed children.

Appendix M

PROJECT S.A.F.E.: A PROGRESS REPORT

Winter, 1979

Central Elementary School

Edgewater, Maryland

The downward extension of educational services to the first two years of life has far-reaching implications for the organization of community services. The principal site of intervention services has shifted from the clinic, preschool and child development centers to the home. Here, in the risk child's natural surrounds, parents and families with professionals, serve as the mediators of interventions through guided interactions with the infant. In the home, constructive interaction opportunities exist throughout the child's day; they are not limited to the therapeutic hour of the clinic or the few hours of preschool experience ...

- Theodore D. Tjossen, Ph.D.
Director, Mental Retardation and
Disabilities Branch of the National
Institute of Child Health and Human
Institutes of Health

PROJECT S.A.F.E.

(Special Assistance for Early Education of the Handicapped)

I. Justification of Program

A REVIEW OF RECENT LITERATURE INDICATES THAT EARLY IDENTIFICATION AND INTERVENTION WITH YOUNG CHILDREN EXHIBITING POTENTIAL AND APPARENT LEARNING PROBLEMS IS EFFECTIVE IN TERMS OF THE CHILD, THE PARENT, THE SCHOOL AND THE COMMUNITY (HAYDEN, 1976; HUNT, 1961; BLOOM, 1964). The value of home-based intervention with these children has also been strongly supported in research investigations (Tjossen, 1974). Project S.A.F.E. staff evaluation, completed by participating parents of children enrolled in the project, echo many of the justifications that have been reported. Generally, support for home-oriented intervention has been based on several contentions:

1. Since the home is the main and almost exclusive environment for children from 0-3, intervention can be accomplished in a natural manner utilizing facilities found in the child's home;

2. Transfer of training is easily achieved between the teacher and parent;

3. The child is in his familiar surroundings and his performance with the teacher is more likely to typify his everyday behavior;

4. The teacher can focus her energies exclusively on the child and parent;

5. The teacher is able to observe any potential problems in the parent-child relationship as interaction occurs in the family's natural environment. Observations can also include potential problems with siblings.

II. Program Site

PROJECT S.A.F.E., BASED AT CENTRAL ELEMENTARY SCHOOL, OPERATES AS PART OF A CONTINUUM OF SPECIAL EDUCATION SERVICES WHICH PROVIDE FOR STUDENTS WITH A VARIETY OF NEEDS, 0-21 YEARS, THROUGH THE FACILITIES LOCATED AT THE CENTRAL SCHOOLS COMPLEX. As illustrated below, children who have participated in the parent-infant program may continue to receive special help when they are age appropriate for a county special education program. Ongoing assessment and periodic review by qualified examiners establishes the appropriate level of service and placement.

	Anne Arundel County Special Education Preschool Programs, 3-5 years
Project S.A.F.E. Parent-Infant Program 0-3 Years	*Early Intervention Preschool Program *Preschool Program for the Hearing Impaired *Preschool Program for the Moderately Handicapped *Preschool Program for Severely-Profoundly Handicapped

III. Staff Development and Continuity

THE DOWNWARD EXTENSION OF SERVICES TO HANDICAPPED CHILDREN, 0-3 YEARS, DEMANDS SPECIALIZED SKILLS ON THE PART OF THE INTERDISCIPLINARY TEAM MEMBERS. In-depth staff development and training activities have been instituted as part of Project S.A.F.E. activities. Participation in the Bureau for the Education of the Handicapped First Chance Network of Early Childhood Projects has afforded staff members opportunities to learn from local, state, and regional experts in the challenging field of early intervention. The following topics illustrate the scope of inservice activities in which staff persons have participated.

*Interdisciplinary Programming for Young Multiply Handicapped Children
*Speech and Language Development
*Educational Intervention with Young Hearing Impaired Children and their Families
*Educational Implications of Physically Handicapping Conditions
*The Educator's Role in Providing Support and Counseling to Parents
*Total Communication Workshop
*Handling and Feeding of Young Cerebral Palsied Children
*Normal and Atypical Motor Development
*Improvement of Communication and Education Skills with Exceptional Parents
*Early Intervention Program Evaluation Techniques
*Development of Appropriate Record Keeping Techniques
*Assessment and Education Program Planning for Severely-Profoundly Handicapped Children

Whenever possible, the staff has extended invitations to appropriate Anne Arundel County personnel to participate in the various workshops and forums.

To date, the staff of the Project has remained intact which has contributed greatly to the effectiveness of the program. INCREASED UTILIZATION OF THE PRESENT STAFF AS PROVIDERS OF INSERVICE TRAINING TO OTHER COUNTY PROFESSIONALS AND PARAPROFESSIONALS CAN BE PROJECTED IN THE FUTURE.

IV. Data Collection and Evaluation

THE CHILDREN SERVED BY PROJECT S.A.F.E. DURING FY 1978 REFLECTED THE ZERO REJECT PHILOSOPHY OF EARLY CHILDHOOD SPECIAL EDUCATION. Disabilities ranged from profoundly handicapping conditions affecting the totality of development to conditions impairing a distinct sensory modality. Consequently, the grouping of children for evaluative purposes is problematic.

The objective of the evaluation process is to collect and interpret data which reports on child progress to parents, staff and sponsor agencies. The evaluation process also yields significant data used in review and moderification of individual and program planning.

The Learning Accomplishment Profile for Infants (Newborn to 33 months) and the Learning Accomplishment Profile (1-60 months) was employed as the primary measuring instrument of child progress. This instrument features a carefully defined sequence of skills that is generally regarded as reflective of the normal developmental pattern. It has the dual advantages of serving as an excellent source for planning activities that conform to the expected emergence of skills in various areas as well as acting as an evaluation tool on which individual progress can be recorded.

In some instances, this tool was supplemented by speech and language tests. The Preschool Language Scale and the Bosch League Scale of Receptive Emergent Language was used particularly in cases of uneven abilities in expressive and receptive language.

Project S.A.F.E. children can be grouped into four major categories of handicapping conditions. These are:

Downs Syndrome
Hearing Impaired/Deaf/Speech Impaired
Multiply Handicapped
Severely and Profoundly Handicapped

A total of 47 children were given home-based and/or preschool services during the year. Each child was pretested on the Learning Accomplishment Profile at entrance to the program. Subsequent evaluations were ongoing in nature, with the home demonstration/classroom teacher responsible for collection of the data. Since ongoing assessment is believed to be integral to the diagnostic/prescriptive model, the individual assessment cycle was adopted. Because some children received Project S.A.F.E. services for only a short period (less than 6 months) these children were not included in the progress evaluation sample. The reasons for short-term placements include; 1) families moved out of county; 2) prolonged hospitalization; 3) placement in more appropriate special education facilities.

For the purpose of analysis, child pre- and post-test data was measured. Gains in developmental age, according to Learning Accomplishment Profile scales, were computed and average progress per month in program was tallied (Insert, Tables A, B, C, & D).

As expected, the highest gainers comprised the Hearing/Language Impaired group whose members typically were disabled in discrete areas, i.e., receiving and/or producing language. These children's average per month gain ranged between .91 (self-help) and 1.1 (fine motor). Signing age and expressive language were considered equivalent.

The multiply handicapped group comprised the second greatest per month gain, with progress ranging from .76 (fine motor) to 1.3 (self help) per month gain. These children present challenging educational needs in terms of teaching to strengths and remediating weaknesses. The staff found many of these children to be well motivated learners in spite of diffuse sensory disability.

Children with Down's Syndrome were the earliest identified and represent the only homogeneous grouping. During FY 1978, three Down's Syndrome children were enrolled prior to five months of age, with one receiving initial services at three weeks. The area of highest achievement was social, with 1.16 average per month gain. However, cognition and language abilities blossomed at an encouraging rate, with progress scores of .85 and .79 respectively. As the Down's population has been traditionally expected to fall into the trainable mentally retarded range (about.50 or 50% of expected chronological age development) we are encouraged by the impact of early intervention in these areas.

Our last group, the severely and profoundly handicapped children, represents the lowest gains in quantifiable terms. Four of the five children in this group have been diagnosed as having quadraplegic cerebral palsy with vision and/or hearing disabilities and retardation.

Evaluation of child progress was especially difficult with our severe and profoundly handicapped and multiply handicapped children. In most cases, severely physical/sensory or mental handicaps drastically lower rate of progress or necessitate atypical or compensatory methods of skill acquisitions. Consequently, measurement of these children's abilities against the "normal yardstick" of growth presented a frustration to project staff. It was generally reflected that the evaluative tools used were not finely tuned enough to detect small qualitative or quantitative growth in some children served by Project S.A.F.E. For instance, the acquisition of head control represents a monumental challenge for some cerebral palsied children and requires extensive facilitative positioning and activities. This skill is also the foundation upon which other motor skills are built.

On an instrument such as the Learning Accomplishment Profile, no progress may be recorded for many months because the child's physical development appears to be halted at the 2-4 month level. On the contrary, as a result of early intervention with parent and child, head control may be steadily and qualitatively improving, but at increments too small to be credited on the Learning Accomplishment Profile.

A similar measurement phenomenom is uncovered with children in our population exhibiting behaviors which are not found in the range of normal development. Extinction or diminishment of such atypical and dehabilitating behaviors as head banging, sustained crying, hyperventilation to point of loss of consciousness, hand biting, and severe malnourishment take precedence for parent and child. However, achievement in these individualized goals does not lend itself to being reflected on developmental scale.

It is the belief of the staff and Project S.A.F.E. parents that the reported progress per Learning Accomplishment Profile and Language Assessment data is encouragingly significant but does not reflect the totality of the progress achieved by the parent/professional teamwork.

A. Hearing Impaired/Speech Impaired N=6

	Pretest	Post-test	Difference	Average Per Month Gain in Program
Learning Accomplishment Profile Gross Motor	25.5	35.0	9.5	.95
Learning Accomplishment Profile Fine Motor	25.0	36.1	11.2	1.11
Expressive Speech/Signing	11.3	20.5	9.2	.92
Language (Receptive)	16.5	25.8	9.3	.93
Learning Accomplishment Profile Cognition	22.5	33.3	10.8	1.08
Learning Accomplishment Profile Social	26.1	35.5	9.4	.94
Learning Accomplishment Profile Self Help	27.1	36.1	9.1	.91

B. Multiply Handicapped N=4

	Pretest	Post-test	Difference	Average Per Month Gain in Program
Learning Accomplishment Profile Gross Motor	16.75	27.75	11.0	1.22
Learning Accomplishment Profile Fine Motor (N=3)	22.16	29.0	6.84	.76
Language (Receptive)	22.75	31.12	8.37	.93
Language/Signing (Expressive)	10.75	21.5	10.75	1.20
Learning Accomplishment Profile Cognition	22.75	32.0	9.25	1.03
Learning Accomplishment Profile Social	28.25	38.0	9.75	1.08
Learning Accomplishment Profile Self-Help (N=3)	18.6	30.67	12.07	1.34

Average Number of months in Program - 9.0

C. Downs Syndrome N=8

	Pretest	Post-test	Difference	Average Per Month Gain in Program
Learning Accomplishment Profile Gross Motor	9.06	17.56	8.5	.77
Learning Accomplishment Profile Fine Motor	9.37	19.25	9.88	.89
Learning Accomplishment Profile Language	9.62	18.3	8.69	.79
Learning Accomplishment Profile Cognition	9.31	18.68	9.38	.85
Learning Accomplishment Profile Social	10.56	23.37	12.81	1.16
Learning Accomplishment Profile Self-Help	10.5	21.5	11.0	1.0

D. Severely/Profoundly Handicapped N=5

	Pretest	Post-test	Difference	Average Per Month Gain in Program
Learning Accomplishment Profile Gross Motor	4.0	6.4	2.4	.20
Learning Accomplishment Profile Fine Motor	3.2	5.3	2.1	.18
Learning Accomplishment Profile Language (Receptive)	4.6	10.4	5.8	.48
Learning Accomplishment Profile Language (Expressive)	3.8	6.4	2.6	.22
Learning Accomplishment Profile Cognition	5.2	8.2	3.0	.25
Learning Accomplishment Profile Social (N=4)	2.8	8.0	5.2	.43
Learning Accomplishment Profile Self-Help	3.6	8.2	4.6	.38

Benefits to the Family

A HOME-BASED EARLY INTERVENTION PROGRAM CAN BE IMMEASURABLE VALUE TO THE ENTIRE FAMILY. All family members must adjust their lives to accommodate the presence of a handicapped child. They may mourn privately and experience a gamut of conflicting emotions. They must plan for the long-range and yet cope on a day to day basis with a significant new impact on their lives.

PARENTS ARE FACED WITH MANY CHALLENGES AS THEY ATTEMPT TO INTEGRATE THIS NEW CHILD INTO THEIR LIVES. IN THE BEST OF SITUATIONS, THERE ARE UNEXPECTED STRESSES.

Project S.A.F.E. has attempted to respond to these needs as soon as possible. Family intervention in the first three years of the child's life is critical since the cumulative effects of guilt, remorse and unarticulated anger may be so great by the time the child is three that it could very possible be too late to be of much value. Before the parent can be effective in dealing with his/her child, he needs to explore the multiplicity of feelings that this child is having on his life.

Services to the family include:

1. Weekly home teacher-psychologist discussions concerning the ramifications of the child's problems on the family unit;

2. Availability of informal psychological counseling to all families;

3. Monitoring of sibling reactions to the presence of a handicapped brother or sister;

4. Opportunities for parents of handicapped children to meet and share common problems;

5. Provision of vital information through monthly parent-community programs featuring guest speakers from the Baltimore-Washington area (see attachment).

Individual counseling and parent group meetings have been cornerstones of the Project philosophy. Due to the relatively small number of families enrolled in the program, family counseling sessions have been tailored to the specific needs of the particular family.

Parent group meetings have been received quite well by Project families. In a February, 1979 survey of families receiving service, the following data were collected:

	Very Important	Important	Unimportant
Meeting other parents whose children have problems similar to my own child.	90	10	0
Meeting other parents and hearing how they are coping with problems I have experienced.	100	0	0
Meeting other parents and learning what they have done to help their child.	90	10	0
Learning how the presence of a handicapped child can affect the whole family.	80	20	0
Learning about community resources.	100	0	0
Having a better understanding of how the medical profession deals with handicapped children.	90	10	0
Gaining information that will be of specific help in working with my child.	100	0	0

Population Served

PROJECT S.A.F.E., AS A HOME AND CENTER BASED DEMONSTRATION PROGRAM HAS SERVED 71 ANNE ARUNDEL COUNTY HANDICAPPED CHILDREN AND FAMILIES SINCE ITS INCEPTION IN FEBRUARY, 1977. The S.A.F.E. staff has also operated as part of the County Child Find effort, with over 150 screenings and evaluations completed to date.

In January, 1979, cooperating health, education and community agencies identified 42 children, ages 0-3 years who will be in need of educational/therapeutic services in school year 1979-80. An additional 20 handicapped children, based on projected figures, also will require appropriate intervention services in school year 1979-80. IN TOTAL, APPROXIMATELY 60 CHILDREN BELOW THE PRESCHOOL QUALIFYING AGE OF 3 BY JANUARY 1, 1980, ARE CANDIDATES FOR A CHILD-CENTERED PARENT ORIENTED PROGRAM.

The children identified include the following areas of handicapping conditions:

- Mental Retardation (Mild/Moderate/Severe-Profound)
- Deaf
- Hearing Impaired
- Orthopedically Impaired
- Visually Impaired
- Speech Impaired
- Multiply Handicapped
- Other Health Impaired

Approximately 75% of the currently assessed children are classified as multiply handicapped, a category designating children with two or more discrete handicapping conditions. Examples of multiply handicapped children currently served by Project S.A.F.E. include a hearing impaired, cerebral palsied child, a profoundly retarded child with visual impairment, and a speech/language impaired child with chronic seizure disorder. The complexities of these combinations of handicaps substantiates the existence of an interdisciplinary staff.

September 28 - Panel discussion on "The Impact of Having a Special Child on the Family: Perspective of Siblings."

October 11 - "An Evening with Dr. Jerry McSpadden, Director of Special Education, Anne Arundel County."

October 18 - Mary Coleman, M.D., "New Research with Downs Syndrome Children."

November 8 - Daniel Dinsmoor, Ph.D., "Language Development Among Pre-Schoolers: Treatment Strategies."

December 5 - Richard Heller, M.D., "Genetic Counseling and Prenatal Testing."

January 9 - Dennis Whitehouse, M.D., "What to Expect From an Evaluation at the Kennedy Institute."

January 31 - Panel discussion on "Educational and Vocational Opportunities with Hearing Impaired Children."

March 7 - Panel discussion on "The Impact of Having a Special Child on the Family: Perspective of Older Parents."

March 13 - "The Components of a Multidisciplinary Project S.A.F.E. Evaluation."

April 19 - John Diuguid, "Estate Planning and Financial Considerations for Parents of Handicapped Children."

May 1 - Linda Jacobs, Ed.D., "How to Evaluate Special Education Programs: A Consumers Guide for Parents."

Appendix N
Letters of Support for Program Continuation

February 6, 1979

Catherine Kressley
Project S.A.F.E. Director
Central Elementary School
130 Stepney Lane
Edgewater, Maryland 21037

Dear Ms. Kressley:

I was quite distressed to receive your letter of February 2 which indicates the possibility of cancellation of the parent-infant stimulation program.

The new knowledge in the field of education has demonstrated that the earlier the stimulation in education is started, the better the results. In fact, the best data so far indicates that if a program of stimulation is started when a child is under six months of age, the single greatest effect of any program of education is achieved. In terms of return for dollars spent from the community point of view, the birth to 3 year age group gives the best return for the educational dollar.

To take one group of patients as an example, Down's syndrome infants are really dependent upon the 0-3 year old programs. In past years, before such stimulation programs were available, the majority of patients grew up to be moderately or severely retarded and remained a burden on the taxpayer for the lifetime of the patient. Since the advent of the infant stimulation program, however, these patients are now functioning in the mildly retarded range and occassionally some of these individuals function in the normal range. This completely changes their prognosis for independent living and independent employment as adults and is an enormous saving to the taxpayers of the community in the long run.

In humane terms, however, which is my main concern in this area, and in scientific terms, infant stimulation programs are the number one therapy prescribed for retarded children. It is like turning the clock back to a time of ignorance in science to deny Down's syndrome and other children the infant stimulation programs.

I have enclosed a bibliography of articles which gives the scientific justification for these concepts and also a paper particularly applying to Down's syndrome children.

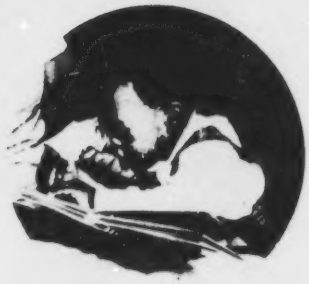
If I can be of any further help in any way, please feel free to call on me. The infant stimulation programs are the keystone for the future for retarded children of all types and should be one of the top priorities of our society.

Sincerely yours,

Mary Coleman, M.D.
Pediatric Neurologist

MC:fh

Early Identification Program
6700 Glenn Dale Road
Glenn Dale, Maryland 20769
301-262-6122



February 6, 1979

TO WHOM IT MAY CONCERN

This is to state that I strongly support the efforts of the Anne Arundel County public school program, "Project S.A.F.E.", to obtain local assistance and support for funding. As coordinator of a parallel program in Prince George's County, I am acutely aware of the great need for this type of service for handicapped infants and preschoolers.

Because of the existence of this exemplary project, Anne Arundel County can consider itself a leader in preschool education in the state and in the nation. Although programs for very young children are, themselves, in their infancy, it should be noted that Maryland state law will be mandating services from birth by September 1980. Presently, 20% of the states provide programs for handicapped children beginning at birth, with more states developing such programs each year. The national trend is for public school systems to incorporate services formerly provided by Associations for Retarded Citizens, Health Departments, Easter Seal Centers, and other agencies.

Research in early intervention is presently being published as the original preschool programs begin to obtain data on the long-term effects of their efforts. Several studies have demonstrated that functional skills can, indeed, be taught to normal and to handicapped infants (Gregg, Haffner & Korner, 1976; Hayden & Haring, 1976; Dodd, 1972; and Bricker & Bricker, 1973). It has been reported that the early developmental period is "one of considerable plasticity and relatively rapid development of the central nervous system", (Kaiser & Hayden, 1977). Many investigators (Hunt, 1961; Bloom, 1964) have suggested that this period of most rapid growth is the optimal time to intervene in the developmental process in order for the greatest effect to result. While the environment is known to be important for the normal baby or toddler, it becomes critical for the handicapped child with highly specialized needs.

In addition to studies with infants, research has shown over several years that handicapped children with preschool experiences do better than children who needed such services but did not receive them by age five or six, (Hayden, Morris & Bailey, 1977). Preliminary findings indicate that children who received early intervention are placed in special education programs less often than control children, and that those placed in regular education do not repeat grades as often as control children (Lazar, 1977).

In conclusion, early intervention has proven itself as a cost-effective means of ameliorating handicapping conditions and of preventing other multiple problems from developing. Time lost in the early years may never be recovered. I urge you to invest in the future of the youngest of Anne Arundel County's handicapped children.

Sincerely,

June Gallagher
Coordinator

JG/en

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ANNE ARUNDEL COUNTY

DEPARTMENT OF HEALTH

THREE HARRY S. TRUMAN PARKWAY ANNAPOLIS, MARYLAND · 21401 · TEL · 301-224

J. HOWARD BEARD, M. D. M. P. H.
HEALTH OFFICER

February 5, 1979

Project S. A. F. E.
Central Elementary School
130 Stepney Lane
Edgewater, Maryland, 21037

Dear Mrs. Kressley,

It is a pleasure to write to you and express my admiration for your program. I have been very pleased with the progress that I have witnessed and believe that such programs that stress early, intensive stimulation will have a beneficial effect as the children mature.

Sincerely,

Pamela R. Moore, M. D.

STATISTICAL SURVEY OF HANDICAPPED PRESCHOOLERS - 0-5 YEARS

Ages as of March 1, 1979

	Deaf	HI	D-B	MR	OH	Other Health	Speech	SED	SLD	VI	Multiply H.	Unassessed	Child Count
0-6 months	--	--	--	1	2	2	--	--	--	--	2	1	3
6-12	--	--	1	4	4	6	1	--	--	1	6	1	9
1-2 years	1	4	--	8	20	22	2	--	--	2	20	5	31
2-2½ years	--	1	--	3	2	4	5	--	--	--	4	4	8
2½-3 years	--	2	--	14	19	12	22	--	--	5	21	12	32
3-4 years	1	12	--	18	10	8	84	--	9	2	44	20	86
4-5 years	--	4	--	24	15	2	71	--	--	3	31	23	80
Total												66	249
0-2½ years												11	51

Does not include children enrolled in Kindergarten Communication Disorder Classes.